THE LANCET.

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CONTENTS.

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THE MILROY LECTURES on Melitensis Septicæmia (Malta or Mediterranean Fever). Delivered before the Royal College of Physicians of London on March 5th, 10th, and 12th, 1908, by J. W. H. EYRE, M.D., M.S. Durh., D.P.H.Cantab., Bacteriologist to Guy's Hospital, and Lecturer on Bacteriology at Guy's Hospital Medical School; Member of the Advisory Board Mediterranean Fever Commission.—Lecture I.—(*Illustrated*)..... 1677

THE INGLEBY LECTURES on the Dangers and Treatment of Myoma of the Uterus. Delivered at the University of Birmingham on May 7th and 14th, 1908, by CHRISTOPHER MARTIN, M.B., C.M. Edin., F.R.C.S. Eng., Surgeon to the Birmingham and Midland Hospital for Women.—Lect. II.... 1682

ORIGINAL ARTICLES.

A Contribution to the Bacteriology of Cerebro-spinal Meningitis. By W. JAMES WILSON, B.A., M.D. R.U.I., D.P.H. Cantab., Joint Lecturer on Sanitary Science, Queen's College, Belfast. (From the Musgrave Pathological Laboratory) 1686

The Treatment of Intractable Hay Fever and Paroxysmal Coryza by Resection of the Nasal Nerve. By EUGENE S. YONGE, M.D. Edin., Honorary Assistant Physician to the Manchester Hospital for Consumption and Diseases of the Throat 1688

The Gastroscope. By ALBERT E. MORISON, M.B., C.M. Edin., F.R.C.S. Edin., Surgeon to the Hartlepools Hospital.—Gastro-Duodenoscopy and Diaphanoscopy. (*Illustrated*) 1689

A Case in which Occlusion of the Abdominal Aorta took place. By C. H. CATTLE, M.D. Lond., F.R.C.P. Lond., Physician to the Nottingham General Hospital 1691

The Treatment of Gangrene in Strangulated Hernia at St. Thomas's Hospital, 1901-1905. By EDRED M. CORNER, M.C. Cantab., F.R.C.S. Eng., Surgeon in Charge of Outpatients at St. Thomas's Hospital..... 1692

A Case of Dissecting Aneurysm of the Pulmonary Artery; Patent Ductus Arteriosus; Rupture into the Pericardium. By LESLIE DURNO, M.D. Aberd.; and W. LANGDON BROWN, M.D. Cantab., F.R.C.P. Lond., Physician to the Metropolitan Hospital; Medical Registrar and Demonstrator of Morbid Anatomy and Physiology, St. Bartholomew's Hospital. (*Illustrated*) 1693

CLINICAL NOTES:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

Case of Pneumococcal Meningitis. By ALEXANDER J. KENDREW, L.R.C.P. Lond., M.R.C.S. Eng., Senior House Physician, Metropolitan Hospital, Kingsland-road, N.E... 1694

Note on a Case in which the Widal Reaction Persisted Seven Years after an Attack of Typhoid Fever; associated with Suppurative Cholangitis, Typhoid Bacilli being found in the Bile Passages. By DONALD E. CORE, M.B., Ch.B. Vict., House Physician at the Derbyshire Royal Infirmary, Derby 1694

REVIEWS AND NOTICES OF BOOKS.

Comparative Anatomy of Vertebrates. Adapted from the German of Dr. R. Wiedersheim by Dr. W. N. Parker. Third Edition 1695

The Cradle of the Deep: an Account of a Voyage to the West Indies. By Sir Fredk. Treves, Bart., G.C.V.O., C.B., LL.D., Serjeant-Surgeon to H.M. the King 1696

A Text-book of Surgical Anatomy. By William Francis Campbell, M.D. 1697

Squint and Ocular Paralysis. By E. Lucas Hughes, M.R.C.S. Eng., L.R.C.P.L. ... 1697

Ueber Abdominale Totalexstirpation des Myomatösen Uterus. Von M. Graefe 1697

Manual of Diseases of the Ear, Nose, and Throat. By John Johnson Kyle, B.S., M.D. Second Edition 1697

Edinburgh Medical Journal ... 1698

The Scottish Medical and Surgical Journal 1698

The Medical Chronicle..... 1698

The Dublin Journal of Medical Science 1698

THE GENERAL MEDICAL COUNCIL.

The Catford Case 1698

The Public Health Committee 1701

The Reading of the Minutes... 1702

The Administration of Anæsthetics 1702

LEADING ARTICLES.

THE MEDICAL MAN AND THE CORONER 1703

THE VALUE OF THE SURREY ISOLATION HOSPITALS 1704

TICS AND THEIR TREATMENT ... 1705

LOOKING BACK.

(From THE LANCET, Saturday, June 12th, 1830.

Protraction of Vegetable Life... 1711

ANNOTATIONS.

The Dangers of Motor Omnibuses 1706

An Early Temperance Tract ... 1706

Milk Epidemic in Christiania.. 1707

"Canary Fever" 1707

Paralysis of the Superior Oblique Muscle of the Eye as a Result of Direct Injury 1708

The Equine Steak 1708

Medico-biological Science in the Italian Upper Chamber.. 1708

Successful Operation for Phlegmonous Gastritis 1709

An Impending Visit of French Medical Men to London 1709

Local Anæsthesia in Minor Surgery 1709

The Drink Craving 1710

Metropolitan Hospital Sunday Fund 1710

VITAL STATISTICS:

Health of English Towns..... 1712

Health of Scotch Towns 1713

Health of Dublin..... 1713

SPECIAL ARTICLES.

Asylum Reports: Kingseat Asylum, Aberdeen; Glasgow Royal Asylum; Barnwood House; St. Andrew's Hospital, Northampton 1702

Medicine and the Law: Insanity a Bar to Valid Marriage; Casual Employment under the Workmen's Compensation Act 1711

Lynn Thomas and Skyrme Fund 1712

Society for Relief of Widows and Orphans of Medical Men 1712

The Services: The British Red Cross Society; Naval Victualling 1713

Notes upon Health Resorts: Scandinavian Winter Health Stations.—V. The Anti-tuberculosis Movement in Norway and Public Sanatoriums for Tuberculous Cases.—(*Illustrated*) 1717

The Belfast Health Commission 1720

The German Surgical Congress.—(*Continued*) 1721

Manchester 1722

Newcastle-upon-Tyne 1722

Scotland..... 1723

Ireland 1724

Paris 1725

Switzerland 1726

Vienna 1726

Budapest 1727

New York 1728

India 1728

CORRESPONDENCE.

Australia for the Sons of Professional Men (Dr. Richard Arthur) 1714

Mr. Coroner Troutbeck and Deaths after Operations (Dr. Major Greenwood)..... 1714

The Grand Ducal Hessian State and the St. George's-Nauheim Institute (Dr. W. Bain) 1715

Tansini Method for the Cure of Cancer of the Breast (Prof. Francesco Purpura) 1715

The Administration of Vaccines by the Mouth (Dr. Arthur Latham)..... 1715

A Disclaimer (Dr. Dudley W. Buxton)..... 1716

The Oldest Institution for Treating Sick Children (Mr. Stewart Johnson) 1716

The Medical Defence Union ... 1716

"As Others See Us" (Dr. A. F. Theobalds) 1735

THE HOSPITAL SUNDAY FUND.

THE LANCET SPECIAL SUPPLEMENT IN SUPPORT OF THE METROPOLITAN HOSPITAL SUNDAY FUND 1739-1746

OBITUARY.

John James Ridge, M.D., B.A., B.Sc. Lond., &c. 1729

Prior Purvis, M.D. Lond., M.R.C.S. Eng., L.S.A. 1730

William King Bullmore, M.D. St. And., M.R.C.S. Eng., &c.. 1731

David Thompson, L.R.C.P., L.R.C.S. Edin., L.S.A., J.P... 1731

Surg.-Gen. Sir J. A. Hanbury, K.C.B., M.B. Dub., F.R.C.S. Eng. & Irel., A.M.S. (retired) 1731

Deaths of Eminent Foreign Medical Men 1731

MEDICAL NEWS.

Medical Inspection of School Children 1682

The International First Aid Congress 1710

The National Health Society... 1716

The Winsley Sanatorium 1723

Pass-list of Trinity College, Dublin 1731

Foreign University Intelligence 1731

The University of London and King's College, London 1731

Motor Accidents in the East-end of London..... 1731

Golf: Church *v.* Medicine 1732

Donations and Bequests 1732

Worthing Hospital 1732

Literary Intelligence 1732

New Water-supplies 1732

Pharmaceutical Society of Great Britain 1732

PARLIAMENTARY INTELLIGENCE.

Notes on Current Topics..... 1732

House of Commons 1732

Books, &c., received 1733

Appointments 1734

Vacancies 1734

Births, Marriages, and Deaths.. 1734

Notes, Short Comments, and Answers to Correspondents.. 1735

Medical Diary 1736

Acknowledgments of Communications received 1738

FOR INDEX TO ADVERTISEMENTS SEE PAGES 2 & 4.

INDEX.

MEDICAL AND OTHER BOOKS AND PUBLICATIONS.

COVER.

PAGE

BAILLIERE, TINDALL & COX:—
Bidwell .... Intestinal Surgery..... 1

BALE, SONS, & DANIELSSON:—
Folia Therapeutica 1
Hood..... Clinical Aspects of Pneumonia..... 1
Moullin .... Inflammation of the Appendix..... 1
" .... Treatment of Gastric Ulcer..... 1

CASSELL & CO.:—
Luff ..... Gout..... 1

GLAISHER:—
Herschell .. Indigestion 1
" .. Cancer of the Stomach 1
Savill ..... Neurasthenia 1

KIMPTON:—
Sandwith.... Medical Diseases of Egypt 1

LEWIS:—
Moullin .... Enlargement of the Prostate 1
" .... Inflammation of the Bladder..... 1

MEDICAL PUBLISHING CO.:—
Curtis ..... Liver Abscesses 1

SAUNDERS COMPANY:—
Saunders' Books 1

SHERRATT & HUGHES:—
Yonge ..... Polypus of the Nose.... 1

SMITH, ELDER & CO.:—
Ellis ..... Demonstrations of Anatomy 1
Marshall & Hurst .... Practical Zoology 1

WRIGHT & CO. (BRISTOL):—
Index of Treatment 1

MEDICAL LIBRARIES, &c.:—
Bonnet—Medical Guide to Chatel-Guyon les-Bains 1

PAGE

MED. LIBRARIES—(Continued).
Davidson & Co.—
Catalogue of Novelties..... 1
O'Connor Extension Co.—
Mechanical Orthopædics..... 11
The Prescriber 1

BAILLIERE, TINDALL & COX:—
Bigg ..... Cancer..... 8

CASSELL & CO.:—
Harris ..... Electrical Treatment .. 6
Hutchison & Rainy .... Clinical Methods 6
Morris, M., & Dore ..... Light and X-Ray Treatment of Skin Diseases 6
Thomson..... Diseases of the Nervous System 6
Whitelegge & Newman Hygiene, &c. 6

CHURCHILL, J. & A.:—
Clowes ..... Qualitative Analysis .. 3
Cripps ..... Cancer of the Rectum .. 10
" ..... Diseases of the Rectum 10
Eden ..... Manual of Midwifery .. 5
Firth ..... Practice of Hygiene 3
Gray ..... Labyrinth of Animals.. 3
Haig ..... Uric Acid 3
Hewlett .... Pathology 3
Jacobson & Howlands.. Operations of Surgery 3
Jellett ..... Practice of Midwifery.. 5
" ..... Practice of Gynæcology 5
Jessop ..... Ophthalmic Surgery .. 3
Longridge .. Manual for Midwives .. 5
Lucas ..... Practical Pharmacy.... 3
Marshall.... Manual of Prescribing 5
Maylard .... Abdominal Tuberculosis 3
Murray .... Hernia..... 3
Parsons .... Diseases of the Eye 3
Smith ..... Medical Jurisprudence 3
Taylor ..... Practice of Medicine.... 3
Wiley ..... Foods and Adulteration 3

CORNISH BROS.:—
Sawyer, Sir J. Maladies of the Heart.. 10
" Contributions to Practical Medicine 10
" Insomnia 10

PAGE

EVERETT & CO.:—
Barton ..... Practice of Equine Medicine 11

FROWDE AND HODDER & STOUGHTON:—
Mayou ..... Diseases of the Eye 9
Parsons .... Pathology of the Eye .. 9
Spencer .... Gunshot Wounds 9
System of Syphilis..... 9
Williamson.. Diseases of the Spinal Cord 9
Writings of the late Sir W. Broadbent 9

GRIFFIN & CO.:—
Lewis ..... Mental Diseases..... 11
Mercier .... Asylum Management .. 11
Wes ..... Organs of Respiration.. 10

HEINEMANN:—
Von Noorden Metabolism and Practical Medicine 8
Williams.... Natural History of Cancer 8

LEWIS:—
Carter ..... Elements of Practical Medicine 5
Coleman .... Extraction of Teeth.... 5
Ehrlich .... Harben Lectures 5
Kanthack .. Preservation of Infant Life 5
Kenwood.... Public Health Laboratory Work 5
Lewers..... Diseases of Women 11
" ..... Cancer of the Uterus .. 11
Martindale & Westcott .. Extra Pharmacopœia .. 6
Murray .... Rough Notes on Remedies..... 5
Parkes & Kenwood.. Hygiene and Public Health 5
Powell, Sir R. D..... Diseases and Disorders of the Heart 5

LONGMANS, GREEN & CO.:—
Goodsall & Miles .... Diseases of the Anus and Rectum 8

PAGE

MACMILLAN & CO.:—
Ballance .... Surgery of the Brain .. 10
Lockwood .. Appendicitis..... 10

RENSHAW:—
Wood ..... Application of Trusts

SANITARY PUBLISHING CO:—
Jensen ..... Modern Drainage Inspection 8

SAUNDERS COMPANY:—
Barnhill & Wales .... Modern Otology..... 7
Campbell .. Surgical Anatomy..... 7
Eisendrath .. Surgical Diagnosis 7
Kelly & Noble .... Gynecology and Abdominal Surgery 7
Kerley ..... Treatment of Children's Diseases 7
Kerr ..... Diagnostics of Children's Diseases 7
Lusk ..... On Nutrition 7
Robson & Cammidge. The Pancreas 7
Theobald .. Prevalent Eye Diseases 7

SMITH, ELDER & CO.:—
Keetley .... Orthopædic Surgery.... 8
" .... Gastric Ulcers 8
" .... Complicated Fractures 8
Tirard ..... Albuminuria, &c. 10

WRIGHT & CO. (BRISTOL):—
Dowse ..... Massage and Electricity 10
First Aid Wall Diagrams 10
Hall ..... Medical Examination for Life Assurance..... 10
Maddox .... Ophthal. Prisms, &c. .. 10
Schlesinger.. Indications for Operation 10
Warwick & Tunstall .. First Aid to the Injured and Sick 10

MEDICAL LIBRARIES, &c.:—
Baker—Bargains in Books 10
Behnke—Stammering 10
Lewis's Medical and Scientific Library 6
Seymour—How to Speak Effectively.. 11

OFFICIAL AND GENERAL ANNOUNCEMENTS.

COVER.

HEALTH RESORTS, BATHS, &c.:—
St. George's Nauheim Institution 1

OFFICIAL NOTICES:—
Royal Society of Medicine 1

APPOINTMENTS VACANT:—
Birmingham General Dispensary 68
Bridgwater Hospital..... 68
Brighton Throat and Ear Hospital .. 68
Bristol Royal Hos. for Sick Children 67
British Hospital, Buenos Aires..... 69
Bucks County Lunatic Asylum, Aylesbury 67
Carmarthen hire Infirmary 70
Carnarvonshire and Anglesey Infirmary, Bangor 68
Chariton-upon-Mediock Dispensary, Manchester 70
City and County of Kingston-upon-Hull 69
City of London Hospital for Diseases of the Chest 69
County Asylum, Burntwood..... 68
County Borough of Derby 70
County Borough of Northampton 67
County Borough of Oldham Education Committee 68
Dehiwe Royal Infirmary..... 68
Dumfries and Galloway Royal Infirmary..... 68
Evelina Hos. for Sick Children.... 69, 70
Farringdon General Dispensary, Holborn Circus 69
Hospital for the Insane, W. Australia 67
Isolation Hospital, Winchmore Hill.. 70
Kent County Asylum, Maidstone 66
King Edward VII. Sanatorium, Midhurst..... 67
Lebanon Hospital for the Insane, Syria..... 66
Leicester Infirmary 69
Liverpool Eye and Ear Infirmary 70
Liverpool Infirmary for Children 68
London County Asylum, Claybury 69
London County Asylum, Horton 69
Manchester Eye and Ear Hospital... 68
Metropolitan Hospital, Kingsland-road 68, 69
Miller General Hospital for South-East London 67, 68
Mountain Ash Urban District Education Committee 69
New Hos. for Women Euston-road .. 70
North Staffordshire Infirmary, Stoke-on-Trent 69
Poplar and Stepney Sick Asylum, Bromley 67
Prince of Wales's General Hospital, Tottenham..... 68
Provincial Hospital, Port Elizabeth 68

APPOINTMENTS—(Continued).
Queen's Hospital for Children, Hackney-road 68
Rangoon Municipality..... 67
Royal Alexandra Hospital for Sick Children, Brighton..... 69
Royal Buckinghamshire Hospital 68
Royal General Dispensary, Bartholomew-close 69
Royal Hampshire County Hospital, Winchester..... 68
Roya' Mineral Water Hospital, Bath 68
Royal South ra Hospital, Liverpool 68
Royal Waterloo Hos. for Children, &c. 68
Salop Infirmary, Shrewsbury 67
St. George's Union London 70
St. Mary's Hospitals for Women and Children, Manchester 67
Sussex County Hospital 68
University of Liverpool 68
Western General Dispensary..... 70
West London Hospital..... 68
Weston-super-Mare Hospital 68
West Suffolk General Hospital, Bury St. Edmunds 69
White Star Line, Liverpool 69
Wolverhampton and Midland Counties Eye Infirmary 67

ASSISTANCIES MEDICAL..... 76

ASYLUMS, HOMES, &c.:—
Ashwood House, Kingswinford 59
Ballbrook House, Bath 59
Barnsley Hall, Bromsgrove 59
Barnwood House Hospital 60
Bishopstone House, Bedford..... 59
Blackheath Invalid Home..... 56
Buntingford House Retreat, Buntingford 62
Buxton House, Earls-Colne 66
Camberwell House, Peckham-road.... 66
Cheadle Royal 59
Clarence Lodge, Clapham-park 59
Coppice, The, Nottingham 60
Crooksbury Sanatorium, Surrey 65
Dadson Nursing Homes 65
Dalrymple House, Rickmansworth .. 62
Dartmoor Sanatorium 65
David Lewis Colony, Alderley Edge.. 58
Earlswood Asylum, Redhill 62
East Anglian Sanatorium, Nayland .. 65
Fairford Retreat, Gloucestershire 59
Flower House, Catford..... 60
Grove House, Church Stretton 60
Grove, The, Catton, Norwich 60
Harley Association, New Cavendish-street 66
Haslemere Nursing Home 58
Haydock Lodge, Newton-le-Willows 61
Helgham Hall, Norwich 59
Hitch, Mrs., Hollington 60
Home for Epileptics, Maghull 66
Hon. Secretary, Outer Temple 66
Inverurie Lodge Retreat, Colinsburgh 61

ASYLUMS—(Continued).
Kingsdown House, Box 59
Lady Superintendent, Streatham..... 58
Lawson, Nordrach-on-Dee, Banchory 62
London Fever Hospital, Islington 59
London Open Air Sanatorium, Wokingham 62
Manor Valley Sanatorium, Peebles-shire 58
Melbourne House, Leicester 60
Middleton Hall, Co. Durham 59
Miss Goffe's Nursing Home, North Finchley 56
Moat House, Tamworth 60
Mrs. C., Clapham Common 58
Newmains Retreat, Lanarkshire..... 61
Nordrach-upon-Mendip Sanatorium .. 62
Northlands Retreat, Wandsworth.... 65
Northumberland House, Finsbury-pk. 66
Northwoods House, Winterbourne.... 61
Norwood Sanatorium 65
No. 116, L.O., Strand..... 66
No. 575, L.O., Strand..... 65
No. 705, L.O., Strand..... 66
Oscaland, Heybridge 65
Peckham House, Peckham-road 61
Physician, Wimbledon..... 66
Plas-yn-Dinas, Merionethshire..... 61
Plympton House, South Devon 60
Sanatorium Clavadel..... 65
Silver Birches, Epsom 66
Springfield House Private Asylum, Bedford 60
St. Andrew's Hospital, Northampton 60
St. Luke's Hospital, E.C..... 59
Stocker, Craven-street 65
Stretton House, Church Stretton 60
Tailerman Treatment Institute 66
The Grange, Rotherham 59
Tower House, Leicester 60
Vale of Clwyd Sanatorium..... 63
Warneford Asylum, Oxford 59
Wonford House, Exeter 60
Wye House, Buxton 60
Yarrow Convalescent Home, Broadstairs 61

FINANCIAL, &c.:—
Birkbeck Bank 57
Equitable Reversionary Interest Soc. 58

HEALTH RESORTS, BATHS, &c.:—
Aberystwyth, the Biarritz of Wales .. 63
Bad Brückenau 65
Bad Kreuznach 65
Bath of Ems..... 64
Cheltenham Spa 63
Chur..... 64
Leysin, Switzerland 65
Neuenahr 64
Rigi-Kaltbad..... 64
Smedley's, Matlock 62
St. James's Electric, Light, and Pine Baths 65
Woodhall Spa Baths..... 65

HOMES WANTED:—
No. 788, L.O., Strand..... 66

HOTELS:—
Barton Court Hotel, New Milton 66
Ilfracombe Hotel 66

HOUSE & ESTATE AGENTS:—
Farmer & Sons, Gresham-street 74
Ilcs, Southend 74
Lough Lincoln's Inn fields 74
Medicus Leadenhall-street 74
Stock well & Co., Plashet-grove 75
Sutton & Son, Manchester 74
Tyser, Greenwood & Co., Chiswick High-road 75
Winton Croft, Binfield 74
CONSULTING-ROOMS:—
Q, Wigmore-street 75

LIFE & FIRE ASSURANCES:—
Prudential 57

MASSAGE:—
Horler, Harlesden 66

MEDICAL ACCOUNTANTS, &c.:—
Turner..... 76

MEDICAL AGENTS:—
Aked & Aked 70
Fieldhall, Limited..... 74
Manchester Medical Agency..... 74
Manchester Medical Association 70
Medical Agency 74
Medical Transfer Agency 73
Moore 70
Needes, Herbert 70
Needes, J. C..... 75
Peacock & Hadley 70
Reynolds & Branson 75
Scholastic, Clerical, &c., Assoc. 71
Turner..... 72
Wilson & Son 73

MEDICAL SCHOOLS (LONDON):—
Cooke's School of Anatomy 56
Medical Graduates' College, &c..... 56
St. Mary's Hospital Medical School .. 55
West London Post-Graduate College.. 56

NURSING INSTITUTES:—
General Nursing Association..... 57
Hospital for Sick Children, Great Ormond-street 57
Leeds Trained Nurses' Institution 58
London Nurses' Association 57
Male and Female Nurses' Assoc..... 66
Male Nurses' Association 57
Male Nurses' Co-operation 59
Mental Nurses' Co-operation, Edgware-road 57
Middlesex Hos. Trained Nurses' Inst. 57
Mrs. Thwaites, Clapham Park 57

(For continuation of Index to Official and General Announcements, and Trade and Miscellaneous Advertisements, see page 4.)

The Milroy Lectures

ON

MELITENSIS SEPTICÆMIA

(MALTA OR MEDITERRANEAN FEVER).

Delivered before the Royal College of Physicians of London on March 5th, 10th, and 12th, 1908,

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LECTURE I.

Delivered on March 5th.

NOMENCLATURE.

MR. PRESIDENT AND GENTLEMEN,—At the very outset I feel that some apology is needed for the title which I have given to these lectures, for in the third edition of the Nomenclature of Diseases drawn up by a Committee appointed by the Royal College of Physicians of London, and published in 1897, there first appears the entry "Mediterranean Fever, synonym Malta Fever," an entry which it is mentioned in the preface has been included "in consequence more especially of representations made by officers of the Medical Department of the Army." This entry refers to the infective disease with which I am immediately concerned, and which had hitherto hidden its identity under a variety of titles, all more or less inappropriate, conferred upon it by various observers; for it is one of the features of the history of the disease, that everyone who has seriously studied it has been extremely dissatisfied with all existing titles and has promptly put forward one which he himself considers as more appropriate, and which he foolishly imagines will soon supplant all previous names. And to this vanity I have also fallen a victim. From the prevailing type of pyrexia some have designated it simple remittent or simple continued fever; from particular clinical features febris sudoralis, gastric, or bilious remittent fever; from its resemblance to enteric fever other observers have called it intermittent typhoid, recurrent typhoid, typho-malarial, or fæco-malarial fever, whilst very protracted cases were often termed Mediterranean phthisis. Other names, identifying the disease with certain localities in which it was prevalent, were Cretan, Cyprus, Gibraltar or "Rock," Malta, Mediterranean, and Neapolitan fevers, while Tommy Atkins, the principal sufferer from the ravages of the disease, has long ago labelled it "slow continued fever." In the fourth edition (1906) of the Nomenclature of Diseases the name and its synonym are found transposed and the name of the island upon which the discovery of the specific organism of the disease was made becomes the principal part of its official designation, to the no small annoyance of the inhabitants who, and with some justice, consider that an undeserved stigma is thereby attached to their native land. Veale in 1879 recognised the erroneous impression that was created by referring to it as Malta fever and suggested that it should be called febris complicata; then, in 1897 Hughes, who had the interests of Malta closely at heart, advocated the use of the name undulant fever as indicating the general characters of the temperature in cases of the disease, but this term has never met with general acceptance. Italian observers have recently applied the title "septicæmia of Bruce" and last year Trambusti suggested the general adoption of the name. This is a step in the right direction, but in my humble opinion, and I make the suggestion with much trepidation, "micrococcus Melitensis septicæmia," or shortly "Melitensis septicæmia," is a more suitable appellation, in that it indicates both the nature of the disease and the specific infective agent. Moreover, it follows the present-day tendency to amplify the information contained in the term septicæmia—that naked term which in the old days of empirical medicine included a multitude of pathological conditions and only justified its existence by serving as a cloak for sins of inadequate and inexact diagnosis—in every case by the addition of the name of the specific microbe responsible for the infection.

The careful study of this disease appeals to us not only as medical men but as members of a great empire, while its importance cannot be gainsaid. It has during the past few years been the custom to generalise and to say that this one disease alone is responsible for a total loss to the combined army and navy on the Mediterranean station of at least 75,000 days' sickness per annum. I do not wish to labour this point—I would merely draw your attention to the accompanying table, which shows the number of cases and the mortality occurring in the Maltese civil population, in the land forces garrisoning the island, and in that portion of our navy which makes Malta its headquarters, during the years 1901–1907.

TABLE I.—*Cases of Melitensis Septicæmia and Mortality in Civil Population, and in the Navy and the Army during the Period 1901–1907 in Malta.*

—	Civil.		Navy.		Army.	
	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.
1901	642	54	252	3	253	9
1902	624	45	354	2	155	6
1903	589	48	339	6	404	9
1904	573	59	333	8	320	12
1905	663	88	270	7	643	16
1906	822	117	145	4	163	2
1907	714	78	12	0	9	1
—	4627	489	1705	30	1947	55

In bringing this instance before you I may perhaps be accused of fostering the impression that Malta is the only habitat of the disease and thereby adducing evidence justifying the nomenclature I endeavour to displace. But I would point out that my own experience of the acute phases of the disease and much of my research work on the etiology of micrococcus Melitensis septicæmia is derived from observations carried out in that island, and that I naturally prefer to draw upon my own experience and upon that of my colleagues upon the Mediterranean Fever Commission, the bulk of which I am personally acquainted with, for any illustrations that may be necessary.

HISTORICAL SUMMARY.

The disease itself may be defined as follows:—

Micrococcus Melitensis septicæmia.—A specific septicæmia, resulting, as its name implies, from infection by the micrococcus Melitensis, widely distributed throughout the subtropics. Endemic in certain localities; running an acute, subacute or chronic course of indefinite duration, often lasting for months or even years, and characterised by lack of constant symptoms other than slight or severe pyrexia—continuous, intermittent, or remittent—and a marked tendency to repeated relapses, during which the symptoms originally present may recur without alteration or diminution of severity; accompanied or followed by such toxic symptoms as neuritis or such metastases as synovitis and orchitis.

Micrococcus Melitensis septicæmia under a variety of names has apparently been known and studied from very early times, for Hippocrates is obviously describing it when he tersely says: "3. In the course of the summer and autumn many fevers of the continual type, but not violent; ..... they were affected with fevers, rigors and deficient sweats, with varied and irregular paroxysms, in general not intermitting ..... the earliest crisis which occurred was about the twentieth day, and in many about the eightieth. But there were cases in which it did not leave them thus at all, but in an irregular manner, and without any crisis; in most of these the fever after a brief interval relapsed again, and from these relapses they came to a crisis in the same periods; but in many they were prolonged so that the disease was not gone at the approach of the winter. Of all those which are described under this constitution the phthisical diseases alone were of a fatal character, for in all the others the patients bore up well and did not die of those fevers." Galen in his Commentary explains the use of the term continual as applied to these fevers by saying that such fevers as have an exacerbation ending in complete apyrexia are called intermittents, whereas such as do not end in a complete remission of the fever are called continual. Hippocrates, moreover (Epidem., lib. iii., Section III., Constitution 2),

describes a case of 120-day fever, terminating fatally, in these words:—

CASE I.—In Thasus, the Parian who lodged above the Temple of Diana, was seized with an acute fever, at first of a continual and ardent type; thirsty, inclined to be comatose at first, and afterwards troubled with insomnolency; bowels disordered at the beginning, urine thin. On the sixth day passed oily urine; was delirious. On the seventh, all the symptoms were exacerbated; had no sleep, but the urine of the same characters and the understanding disordered; alvine dejections bilious and fatty. On the eighth, a slight epistaxis; small vomiting of verdigris-green matters; slept a little. On the ninth, in the same state. On the tenth, all the symptoms gave way. On the eleventh, he sweated, but not over the whole body; he became cold, but immediately recovered his heat again. On the fourteenth, acute fever; discharges bilious, thin, and copious; substances floating in the urine; he became incoherent. On the seventeenth, in a painful state, for he had no sleep, and the fever was more intense. On the twentieth, sweated all over; apyrexia, dejections bilious; aversion to food, comatose. On the twenty-fourth, had a relapse. On the thirty-fourth, apyrexia; bowels not confined, and he again recovered his heat. Fortieth, apyrexia, bowels confined for no long time, aversion to food; had again slight symptoms of fever and throughout in an irregular form; apyrexia at times and at others not; for if the fever intermitted and was alleviated for a little it immediately relapsed again; he used much and improper food; sleep bad; about the time of the relapse he was delirious; passed thick urine at that time, but troubled and of bad characters; bowels at first confined, and again loose; slight fevers of a continual type; discharges copious and thin. On the hundred and twentieth day he died. In this patient the bowels were constantly from the first either loose, with bilious, liquid, and copious dejections, or constipated with hot and undigested feces; the urine throughout bad; for the most part coma or insomnolence with pain; continued aversion to food. Ardent fever. *Explanation of the characters.* It is probable that the weakness produced by the fever, the phrenitis, and affection of the hypochondrium caused death on the hundred and twentieth day.

Hippocrates records another case of similar duration which followed its usual course and terminated in recovery. These cases, read in the light of our twentieth century knowledge, must undoubtedly have been cases of micrococcus Melitensis septicæmia; indeed, in the Sydenham Society's translation of Hippocrates's works published in 1849, Adams remarks of the former that "this is an example of one of those protracted fevers which, as I have been informed by an intelligent physician who practised for several years in the Ionian Islands, are so common in the climate of Greece." In another place, referring to certain of the fevers described by his author, Adams states that a careful study of modern authorities convinced him that these fevers "are exactly the same as those which are now described as still prevailing in the land of Greece and correspond very well with those described by Cleghorn (as occurring in Minorca)." Cleghorn himself (1750), Veale (1879), and Hughes (1897) are all in turn struck by the applicability of these descriptions to the disease as it manifested itself in their days, and so set the example of quoting Hippocrates which I have now followed.

From the first to the nineteenth centuries descriptive accounts of any subtropical fever which can be identified with the one under discussion are extremely rare. Some of those described by Bates in the first decade of the eighteenth century probably belong to this category as does the *febbre subcontinua* of Torti a few years later.

Hughes, who, assisted by Zammit, made a careful research through the Bibliotheca of Valetta, a library which is particularly rich in rare, and in many cases unique, manuscripts, records the fact that Bonamici (1626–1680) described a fungus indigenous to Malta—Fungus Melitensis (Cynomorium coccineum Balanophoraceæ, order Rhizanthal), which was held to be a sovereign remedy for the "fever" and a valuable monopoly of the Grand Masters—a fact which was considered of sufficient importance and interest to be reiterated in 1805 by Louis de Boisgelin; he also states that Demarco (1722–1787) refers to the occurrence of continued and remittent fevers in Malta. Howard in "Lazaretos of Europe (1786)," too, describes a low form of fever prevalent in the wards of the Great Hospital of the Knights of St. John.

Cleghorn, surgeon to the 22nd Regiment of Foot, writing of the "epidemical diseases in Minorca during the period 1744–1749" states: "Yet I have seen every year a few [cases of fever] of the continual kind; ..... some of them have continued without any considerable Interval for six or seven Weeks. Hippocrates has accurately described such." The administration of "bark" produced no effect in these cases and he further says: "..... nor could I ever fall upon any certain Method of preventing one Relapse after another until the cold Weather which commonly sets about *Christmas*, had braced the Solids and given them sufficient Strength to throw off the excrementatious Humours by the proper Outlets." Incidentally Cleghorn remarks that the island abounds with goats, which "are fattened in Autumn and are slaughtered from September to January chiefly for the use of the common people." Fauverage (1803) and Robert, military surgeons to the French troops during their occupation of Malta (1798–1800), also mention "the bilious maladies, the intermittent fevers, &c., affect most especially the inhabitants of Malta."

The next author of importance to treat of the disease is Burnett (1814), in a volume which bore for its main title the words "Mediterranean Fever," followed on the next page by a lengthy descriptive title commencing "A Practical Account of the Fever commonly called the Bilious Remittent as it appeared in the Ships and Hospitals of the Mediterranean Fleet ..... and of the Gibraltar and Carthagena Fevers." This author describes the onset of the disease clearly and fully, mentions the pains in the joints, the throbbing of the carotids, the swelling of the parotids, and the petechiæ which occur during the course of the disease, and in a footnote makes the significant statement that the "patients were constantly relapsing." Burnett describes his numerous cases so clearly that the present-day student can readily pick out those of Melitensis septicæmia and distinguish them from those of typhus, typhoid, and yellow fever, yet in the preface this author states his opinion that the fevers he treats of are all identical and that copious venesection forms the only treatment.

Other military and naval surgeons—Irvine, Hennen, Burns, Baxter, Clark, and Davy—in turn took up the study of the fevers met with in the Mediterranean and a perusal of their writings leaves no shadow of doubt that Melitensis septicæmia was prevalent in both services, although there is equally no doubt that all the authors to whom reference has so far been made frequently confused it with enteric fever on the one hand and malaria on the other.

Parliamentary returns of the diseases of the navy and army during the first half of the nineteenth century bear internal evidence in those sections dealing with the Mediterranean Station of the prevalence of micrococcus Melitensis septicæmia under such headings as "remittent fever," "bilious remittent," "common continued," &c., but it is not until 1863 that we find in the belated report of Marston an accurate account of the clinical symptoms which enabled him to differentiate micrococcus Melitensis septicæmia, or, as he called it, "Mediterranean remittent" or "gastric remittent," from the other fevers of the Mediterranean, including simple continued or ephemeral fever—a three- to five-day fever which he refers to as febricula or Maltese fever. He defines the Mediterranean remittent as "a fever characterised by the following symptoms and course: a preliminary stage of subacute dyspepsia, anorexia, nausea, headache, feeling of weakness, lassitude, and inaptitude for exertion, mental or physical, chills, muscular pains; lastly, a fever having a very long course—three to five or ten weeks—marked by irregular exacerbations and remissions, great derangement of the assimilative organs, tenderness in the epigastric region, splenic enlargement, slight jaundice without any exanthem. ..... The patient is prone to relapses and the disorder is followed by a protracted convalescence and a chloro-anæmic aspect; very frequently also by rheumatism of some form or other. The skin ..... at another time (night) is covered with perspiration, sour smelling and acid to litmus. ..... From first to last there is great depression of spirits. ..... The occurrence of wintry or cold weather acts most beneficially. ..... The tendency of the disease is decidedly to recovery—a fatal issue being very rare indeed." Further on Marston states that the rheumatism of the convalescent stage takes one or other of the following forms: (1) sciatica; (2) rheumatic orchitis (only one case suppurated); (3) general rheumatism; or (4) intercostal neuralgia.

Veale, the assistant professor of military medicine at Netley, contributed in 1879 a very complete account of the clinical symptoms presented by patients suffering from the disease when invalided home from Cyprus, Malta, and Gibraltar, together with observations upon the morbid anatomy of the affection. He lays particular stress upon the frequency with which rheumatic sequelæ occurred in invalids from Malta and Gibraltar and from this fact contends that the bulk of the fevers contracted in Cyprus were not identical with the fever so common in Malta and Gibraltar.

In the same year Fazeo described the disease as it occurred in Naples to the Association of Medical Men and Naturalists, and in pointing out its specific characters suggested the probability of the *causa causans* of the disease being a micrococcus or some allied microbe.

In 1886 Bruce, as a surgeon-captain in the Army Medical Staff and while stationed at Malta, first observed the specific micro-organism which is the causative factor in the production of micrococcus Melitensis septicæmia; and although in those days bacteriology was a comparatively juvenile science, he applied its principles to his investigations and early noted the presence of minute cocci in fresh preparations of the spleen pulp. In the following year he isolated and described the micrococcus and by experiment upon the monkey proved its etiological importance.

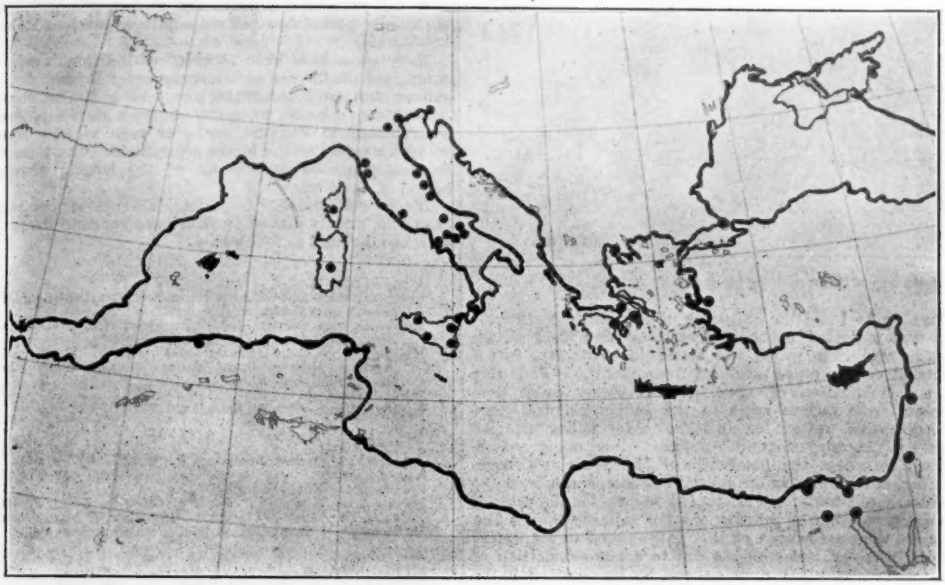
In those days the Army Medical Department did not see the wisdom of providing facilities for its officers for research work, and Bruce accordingly associated himself with Sciciuna, the Government analyst, in whose laboratory the cultivation and inoculation experiments were carried out. The organism was isolated from the spleen pulp of several fatal cases and was found to fulfil the postulates of Koch. Bruce described his experiments in a preliminary note in the *Practitioner* for September, 1887, and in his next paper, contributed to the *Annales de l'Institut Pasteur*, he described his experiments in full, and by a chain of incontrovertible evidence established the specificity of the organisms he had isolated.

Bruce did not write at any great length upon the purely clinical aspects of the disease, but some ten years later Hughes (when also stationed at Malta) stimulated by the example and advice of Bruce, devoted himself to this aspect of the subject, and having amplified and confirmed the experiments of his teacher produced a monograph on the subject which from the clinical side ranks as the classic. Immediately previous to the publication of Hughes's work Wright, then professor of pathology in the Army Medical School at Netley, took up with his pupils the investigation of the disease and soon showed experimentally that specific agglutinins were present at some period or other during the course of the experiments in the blood of infected and immunised animals which were comparable to those already described by Durham, Gruber, and Widal in connexion with cholera and enteric fever. It was further shown that similar agglutinins could be demonstrated in the serum of patients who had acquired the disease naturally, whilst as they were absent from the serum of patients suffering from other diseases as well as from the serum of the normal individual their detection formed a reliable means of diagnosis. These observations upon the specific agglutinins of micrococcus Melitensis septicæmia—affording as they did an accurate basis for the differential diagnosis of obscure fevers—were eagerly applied by many observers. But it was probably nearly the end of 1900 before the agglutination test in one or other of its forms was being generally applied by both naval and military surgeons. Hence in the compilation of statistics—that is, where accuracy of diagnosis is a very essential detail—it is advisable to use only such as are available from 1901 onwards.

GEOGRAPHICAL DISTRIBUTION.

Unfortunately after Bruce had left the Mediterranean his exact researches provoked very little interest amongst the bulk of those whose duties brought them into close clinical touch with the disease. But, as I have already mentioned, the observations of Wright, providing as they did a ready means of diagnosis, were eagerly applied, and for many years the only direct advances made in the study of Melitensis septicæmia were those bearing upon its geographical distribution, for from all parts of the tropical and subtropical zones sporadic cases and small epidemics were recorded, showing most conclusively that although the Mediterranean was a perfect hot-bed of the disease many others of our possessions beyond the seas shared the unenviable distinction of harbouring this fever. Hughes, when discussing the distribution of the fever, remarked upon the fact that north of latitude 46° N., which corresponds roughly with isotherm 55° F., this fever does not exist except as imported cases. South of this line the fever is met with as an endemic disease with an increasing annual prevalence as the mean annual temperature rises above 60° F.

FIG. 1.



Map of the Mediterranean Basin indicating by black areas and spots those localities where septicæmia Melitensis is endemic.

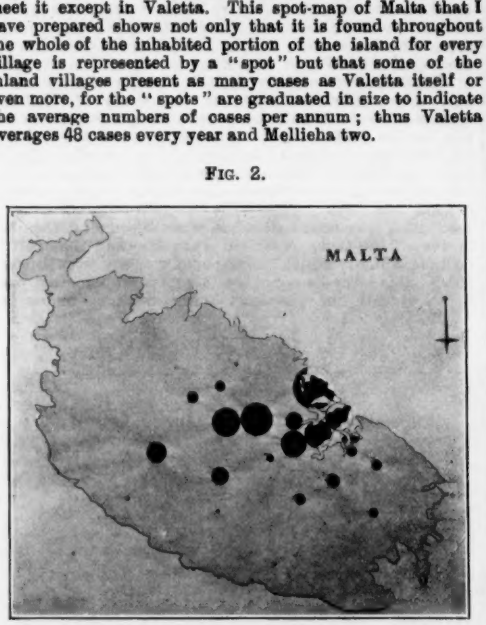
Shaw, in a paper communicated to the Royal Institute of Public Health at its London congress in 1905, maintained that the fever was infrequent and rare elsewhere than in Malta, and to put it plainly only occurred in such localities as were in direct sea communication with Malta.

So far as concerns the Mediterranean area, however, the evidence of the almost universal distribution of the disease is fairly complete. At Gibraltar the disease was well known until its disappearance from the Rock a few years ago. In Algiers the researches of Brault, Soulie, and Sergent, and in Tunis of Hayat, Nicholle, Schoull, and Cathoire have placed the existence of the fever beyond doubt. Manoussos, Brussis, and Thomopoulos record cases from Greece; Kaller from Smyrna; Ross from Port Said; Carbone, Gabbi, Trambusti, and others from Sicily, and practically the whole of Southern Italy, and so on, and the cases recorded are supported not merely by clinical evidence but also by the

agglutination reaction and by the isolation of the specific micrococcus, either from the peripheral blood during the progress of the disease or by its recovery from various organs after death, and in some instances from both these situations. Zardi, Tiberti, and Catani junior, on similar evidence prove its existence in Tuscany; Gabbi also notes its presence in Leghorn and Ancona, and Brunner in Trieste.

In Malta itself it was customary at one time to deny that the disease existed elsewhere than in the immediate neighbourhood of the Grand Harbour, and that it was rare to meet it except in Valetta. This spot-map of Malta that I have prepared shows not only that it is found throughout the whole of the inhabited portion of the island for every village is represented by a "spot" but that some of the inland villages present as many cases as Valetta itself or even more, for the "spots" are graduated in size to indicate the average numbers of cases per annum; thus Valetta averages 48 cases every year and Mellieha two.

FIG. 2.



Spot map of Malta showing incidence of septicæmia Melitensis.

Turning to India the existence of Melitensis septicæmia was first indicated by the observations of Wright on the specific agglutinin which was found to be present in th serum of certain cases invalided from Subathu. Following on the publication of these results many cases were reported from various spots in the Indian Empire where the diagnosis rested on clinical observations coupled with positive agglutination reactions. But many writers refused to accept the possibility of Melitensis septicæmia existing, particularly as an endemic disease, apart from the Mediterranean basin, and attempted to question the value of the serum reaction by pointing out the fallacies that at first atterded the employment of this new method of laboratory investigation—fallacies mainly due to a non-recognition of the precautions which must necessarily be observed in the application of any test, and for a while it was the fashion to deny that Melitensis septicæmia had any place among the indigenous diseases of India. Evidence steadily accumulated, however. Finally, in 1905 Lamb, of the Indian Medical Service, and Kesava Pai investigated in a most comprehensive manner an epidemic of the disease at Ferozepore, during which the specific micrococcus was recovered from various patients and the accuracy of the diagnosis conclusively established, while Forster tracked down the source of infection. Recently Brayne has investigated an epidemic of Melitensis septicæmia occurring in the 36th Sikh Regiment in Rawalpindi, when the clinical diagnosis was supported by the serum reactions, and although no attempts were made to isolate the specific coccus, incontrovertible evidence was adduced by Fox to show that the regiment was being supplied with infected and infective food; and still more recently Mills of the 22nd Punjabis writes me from Jhelum saying that there are cases there in one of which micrococcus Melitensis has been recovered in pure culture from the peripheral blood.

Still further East, Bishop, who himself suffered from the disease, states that it is endemic in Hong-Kong and Shanghai. My late friend and colleague Washbourn on his return from South Africa early in 1901, expressed to me his conviction that Melitensis septicæmia existed in South Africa—in Kimberley (diagnosed as camp fever) and elsewhere—his opinion being based upon the results of agglutination reactions carried out early in 1900 where the serum had been tested against a vigorous and virulent strain of micrococcus Melitensis I had provided him with; but as none of the cases had proved fatal, the urgency of his routine work had prevented any attempt to isolate the coccus.[1] My knowledge of the disease in South Africa and its distribution there is derived from (in addition to official records) the papers published by Strachan and from private letters I have received from him, from Dr. W. W. Stoney, and from Major J. G. McNaught, R.A.M.C., to all of whom I am deeply indebted for many details. From these correspondents I gather that Melitensis septicæmia is widely diffused throughout the Transvaal, British Bechuanaland, Orange River Colony, Basutoland, and Cape Colony, as will be seen from the accompanying spot map of South Africa prepared from information supplied by the gentlemen I have just named.

Two sporadic cases have also been recorded as occurring in England in addition to several authenticated cases of laboratory infection. Of these the one mentioned by Birt and Lamb in THE LANCET of Sept. 9th, 1899, if in verity a case of Melitensis septicæmia, of which fact there does not appear to be any overwhelming evidence, might well have been a laboratory case. The second, recorded by Mangin in the same year in a young gunner who had never been out of England, would from the general course of the disease and the naked-eye appearances at the necropsy suggest chronic streptococcic septicæmia quite as much as Melitensis septicæmia.

Many cases have been recorded of individuals who have contracted the disease within some endemic area and there suffered from an indefinite malaise, so slight as to cause but little inconvenience, of a day or two's duration, and on their return to England weeks or even months later developed a severe attack of the septicæmia. These cases are frequently quoted as evidence of the lengthy incubation period of the disease.

The various localities in which Melitensis septicæmia has been conclusively proved to exist as an endemic disease may then be tabulated as follows:—

Europe.
Austria (Trieste).
Grecian Archipelago.—Athens, Nauplia, Platæa, Cephalonia (Argostolia), Corfu, Crete.
Italy.—Ancona, Benevento, Campobasso, Casserta, Cittanova, Fermo, Leghorn, Naples, Padua, Pisa, Rome, Terano.
Mediterranean Sea.—Balearic Isles (Mahon), Candia, Corsica (Ajaccio), Cyprus, Gozo, Malta, Sardinia, Sicily (Catania, Messina, Palermo, Syracuse).
Spain.—Gibraltar.
Turkey.—Constantinople, Salonika.

Asia.
Arabia.—Aden.
Asia Minor.—Beyrout, Jerusalem, Smyrna.
Assam.—Tezpur.
China.—Hong-Kong, Shanghai.
India.—Agra, Allahabad, Bombay, Calcutta, Delhi, Ferozepore, Jalandhar, Jhelum, Lucknow, Meenmer, Multan, Nowshera, Rawalpindi, Secunderabad, Simla, Subathu, Swat Valley.

Africa.
Algeria.—Algiers.
Tunis.—Cape Bon, Goulletta, Tunis.
Egypt.—Alexandria, Cairo, Massowah, Port Said, Suakin.

South Africa.
Basutoland—Leribe, Maseru, Mohalieshoek.
Cape Colony.—Barkly West, Beaufort West, Clanwilliam, Griquatown, Hanover, Hopetown, Kenhardt, Kimberley, Murraysburg, Pearston, Petrusville, Prieska, Richmond, Somerset East, Upington.
Native Provinces.—Hay, Maclear, Mount Fletcher, Ugie.
Orange River Colony.—Bethulie, Boshof, Fauresmith, Ficksburg, Koffyfontein, Luckhoff, Philipolis, Reddersburg, Senekal, Springfontein, Vrede, Wepener.
Transvaal.—Barberton, Boksburg, Dordrecht, Johannesburg.

America.
North America.—Mississippi Valley.
South America.—Brazil, Venezuela, Montevideo.
West Indies.—Cuba, Porto Rico.
Pacific Ocean.—Fiji Islands, Philippine Islands (Manila).
Atlantic Ocean.—Canary Islands.

[The lecturer proceeded to consider the etiological factors of the disease, reviewing the old opinions which held it due to "the influence of marsh miasma," or its first-cousin

[1] See also Brit. Med. Jour., Sept. 14th, 1901, p. 701 (Pathological Notes from South Africa, pp. 699–701).

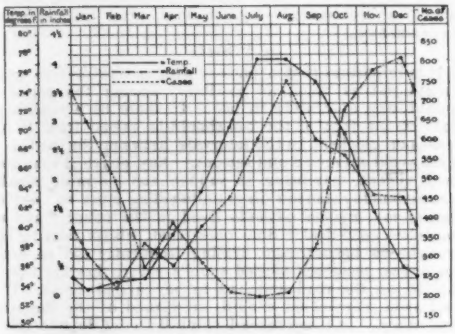
"the constant breathing of a fæcally polluted atmosphere," as stated by Burnett in 1814, and the later theories which would have it a dirt disease, and especially due to imperfect drainage. He stated that in 1905 Davies, after surveying the incidence of the disease amongst the Malta garrison, considered that the data available were insufficient to justify any absolute and definite conclusions upon the subject." He continued:]

I now propose to deal very briefly and without comment at this stage with certain etiological data—observed facts—bearing upon the incidence of the disease in relation to such factors as age, status, seasonal prevalence, atmospheric temperature, &c. For reasons already given all my illustrations in this connexion are drawn from one particular endemic area—viz., the island of Malta—and I may remark that I have drawn largely upon the epidemiological portions of the reports of the Mediterranean Fever Commission, supplemented by the official publications of the public health department of Malta, for the material for this section.

SEASONAL PREVALENCE.

The climatic conditions prevailing in Malta enable one to make the general statement that the year is divisible into a hot dry season from April to September, and a cold wet season from October to March. Again, speaking generally, the average incidence rate is lowest during the wet period from November to January, rises slowly and gradually during February to April, more rapidly during May and June and reaches its maximum during the very hot dry months of July, August, and September, months which, it may also be remarked, correspond to the greatest prevalence of insect life and also of dust. So that in general terms a very close correspondence is to be observed between the curves recording atmospheric temperature and incidence rate, and a direct opposition between those representing incidence rate and rainfall, which is well seen in the chart drawn up by Johnstone in 1904 from civil statistics (Fig. 3). At the same

FIG. 3.



Relation of incidence rate to temperature and rainfall (Johnstone).

time it must be noted that cases occur throughout the entire year, and in examining figures for individual months in preparing yearly averages, &c., it is seen that the incidence is markedly irregular, and that often a large number of cases will appear in cold rainy months—e g., December or January, as for example in the military statistics for the period 1901–1906.

GENERAL SANITARY CONDITIONS.

The towns and villages in Malta can be grouped under three headings so far as general sanitation is concerned—viz., 1. An urban drained area comprising Valetta, Floriana, and the three fortified cities Cospicua, Vittoriosa, and Senglea, towns which are drained, paved, and scavenged. 2. A suburban partially drained area comprising Sliema (sewered 1902), St. Julian (1903), Hamrun, Misida and Pieta (1903), Birchircara, Curmi, Zabbar, Tarxien and Paola. 3. A rural area comprising Notabile and Rabato, Dingli, Zebbug, Siggeui, Lia, Attard and Balzan, Naxaro, Musta, Gargur, Mellieha, Lucca, Zurrico, Safi, Crendi, Micabiba, Chircop, Zeitun, Axiak, and Gudia. The combined population of each of these three areas is practically the same, but the incidence-rate per 1000 for 1904–1906 shows that the disease is most prevalent in the suburban area and least prevalent in the urban area, while in the rural area the incidence practically corresponds to the average for the whole island, which is 3·86.

Urban area, 61,242	2·99
Suburban area, 59,877	5·08
Rural area	3·61

According to Johnstone, disregarding the urban area, the greater the aggregation of inhabitants living in one locality the greater is the proportional number of cases that occur amongst them; also to a certain though less marked extent severity of incidence depends on density of population.

Length of residence in endemic area.—Malta.—The duration of residence—the length of service—in Malta of those adults who are not natives of the island is closely connected with the incidence rate, the newcomers during their first year in Malta yielding by far the largest number of cases. After the first year of residence the incidence gradually decreases until the fifth year, after which it again rises, to suffer a second fall when the period of residence has been prolonged beyond ten years.

TABLE II.—*Length of Service in Relation to Melitensis Septicæmia (Army in Malta).*

Length of service.	Aggregate strength, 1902–1903.	Notified cases.		Deaths.
		Total.	Ratio per 1000.	
Under 1 year ...	17 820	839	47·0	14
1 to 2 years ...	11,356	454	39·9	12
2 „ 3 „	4,016	140	34·8	8
3 „ 4 „	1,197	41	34·2	4
4 „ 5 „	712	14	19·6	—
5 „ 10 „	657	32	48·7	2
10 years and over	187	2	10·7	1

Age and sex.—A consideration of the statistics of the civil population for the year 1905 (when the figures in this connexion were first available) and 1906 shows that the disease is most prevalent between the ages of 11 and 30 years, though no age is immune, for I have seen a case of micrococcus Melitensis septicæmia in a woman who I was told was

TABLE III.—*Incidence of Melitensis Septicæmia in Relation to Age and Sex (Civil Population).*

Age—years.	Males.		Females.	
	Population.	Cases.	Population.	Cases.
0–10	19,762	62	19,105	64
11–20	16,334	173	16,336	183
21–30	13,324	221	13,227	189
31–40	10,257	117	10,412	107
41–50	9,042	76	9,224	85
51–60	6,818	59	6,842	62
61–70	3,991	33	4,189	18
71–80	2,062	7	2,190	3
81–90	723	2	729	1
Totals	82,303	750	82,254	712

turned 86 years—and looked it—and I have seen another in an infant but a few days old. From civilian statistics sex would appear to be an indifferent factor. The above total of 1462 cases is made up of 750 males and 712 females, while the total population at the last census (1901) comprised 91,994 males and 92,748 females. On the other hand, military statistics would indicate that women are more than twice as susceptible as the rank and file, being 88·2 per 1000 as compared with 41·1, the mortality rates corresponding directly with the incidence rates, although there is sufficient general agreement between civil and military statistics with regard to the age-incidence of the disease.

TABLE IV.—*Age in Relation to Melitensis Septicæmia (Army in Malta).*

Age—years.	Aggregate strength 1902–1905.	Notified cases.		Deaths.
		Total.	Ratio per 1000.	
Under 20	4,827	190	39·3	4
20–25	14,774	811	54·9	13
25–30	7,423	233	31·3	7
30–35	4,205	125	29·7	9
35–40	3,871	120	31·0	5
40 and over ...	845	43	50·9	3

Social status.—Exact statistics bearing upon this point in relation to the civil population of Malta are not obtainable but it is a widely spread impression that the upper leisured classes are much more prone to contract the disease than the lower and labouring classes. Maltese physicians support this impression which receives some confirmation from the fact that the combined suburbs of Sliema and St. Julian, the most fashionable and wealthiest locality of the island, have by far the heaviest average case incidence—viz., 74 per 10,000 inhabitants—but personally I am not altogether convinced of the truth of the statement, for my own experience leads me to believe that the Maltese peasant when suffering from the disease, so long as he is not absolutely incapacitated, will prefer to work during the early hours of the day before his temperature rises to an inconvenient height and rest during the post meridian hours rather than call in a medical man. Consequently severe cases alone are seen by the physician and notified, a fact which goes far to explain the high case mortality of Melitensis septicæmia noted in the civil population of Malta as compared with that observed in the navy and army. In one small holding or allotment which I inspected the peasant farmer and two of his children were suffering from Melitensis septicæmia, none of them were notified and none of them were even under medical observation. Statistics from the military records, however, show clearly that the officer has a much greater liability to attack than the men, although the disease is much less fatal in the officer.

Occupation.—Statistics dealing with the relationship existing between occupation and the incidence of Melitensis septicæmia are not available so far as concerns the civilian population of Malta. Figures obtained from the services, however, show that a very close association used to exist between the occupation—if occupation it may be called—of the invalid and the incidence of the disease. This is well shown by a table prepared by Johnstone (Mediterranean Fever Commission Reports, Part II.) for the three large hospitals of the island—civil, naval, and military respectively. An equally if not more dangerous occupation was that of nursing, as is shown by returns of cases amongst the staffs of both military and civil hospitals. Of the rank and file of the army the occupations that showed the heaviest incidence were barrack cooks, officers' servants, mess waiters, grooms, and laboratory attendants, which together supplied more than one-fifth of the entire number of cases occurring in the garrison, and on tabulating the cases in the army in 1905, under what may be termed the "dangerous" occupations, we find that together they are responsible for 78 out of a grand total of 144 admissions for Melitensis septicæmia:—

Dangerous Occupations.

Hospital in-patients	23
Royal Army Medical Corps orderlies	16
Barrack cooks	16
Officers' servants	12
Mess waiters	6
Grooms	3
Laboratory attendants (also Royal Army Medical Corps orderlies)	2
	78

MEDICAL INSPECTION OF SCHOOL CHILDREN.—At a meeting of the Gloucester education committee held on May 30th it was decided to appoint an assistant medical inspector of school children at a salary of £250 per annum, increasing to £300 by annual increments of £10.

The Ingleby Lectures

ON

THE DANGERS AND TREATMENT OF MYOMA OF THE UTERUS.

Delivered at the University of Birmingham on May 7th and 14th, 1908,

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SURGEON TO THE BIRMINGHAM AND MIDLAND HOSPITAL FOR WOMEN.

LECTURE II.[1]

Delivered on May 14th.

GENTLEMEN,—In my first lecture I discussed the various dangers of myoma and the complications that may arise. I also pointed out the slender hope there was of a natural cure by extrusion of the growth per vaginam, by absorption after confinement, or by atrophy at the menopause. To-day I propose to direct your attention to the treatment of the disease. We may divide the various remedial measures into the medical and the surgical. Let us first consider the medical (or non-surgical) methods of treatment.

I.—NON-SURGICAL TREATMENT.

If a patient has only a small myoma, which is not growing, not causing pain, severe hæmorrhage, or interference with her health or comfort, we are not justified in advising her to undergo an operation. The case should be watched and the growth examined at regular intervals to see if it be really quiescent. A fibroid which is not actively growing may yet vary in size from time to time, being larger and more vascular just before the period and smaller after it. This is most noticeable in those cases where there is much menorrhagia. Hence, to ascertain if the tumour be really growing or not it should be examined at the same time after each period—say one week after the cessation of menstruation.

Rest.

It is important that a patient with a troublesome myoma should rest as much as possible. During the period she should stay absolutely in bed. If there be a tendency to flooding the foot of the bed should be raised from 12 to 18 inches on blocks. In the intervals between the periods she must avoid all strain and fatigue. Any physical exercise, if at all violent, may bring on sudden and alarming bleeding. Hence dancing, horse-riding, and cycling must be forbidden. One of my myoma patients lived in the country and used to cycle a good deal. She found that, whilst walking never brought on hæmorrhage, cycling frequently did so, and on one or two occasions caused such a severe flooding that she fainted on the road and had to be carried home. If the patient be married she should be warned of the dangers of pregnancy. In these cases I think it is our duty to tell the woman and her husband to take suitable measures to prevent conception. In all cases of polypus, in most submucous and in many interstitial fibroids, it will be found that sexual intercourse is apt to start hæmorrhage. In such cases coitus must be forbidden.

Supporting the Uterus.

The patient should be forbidden to wear corsets, as they tend to press the tumour down into the pelvis. At the same time, by obstructing the abdominal veins they keep up a condition of chronic venous congestion in the uterus and so favour hæmorrhage. On the other hand, the wearing of a light abdominal belt is sometimes beneficial, especially where the tumour is subserous, of large size, and is pressing on the bladder, the pelvic veins, and nerves. Here a well-fitting belt may comfort her by taking some of the weight of the tumour off these structures. It is sometimes useful to support the uterus from below by means of a pessary, especially in those cases of small myomata which cause retroflexion and retention of urine. In such cases the urine should be drawn off with a catheter, the patient placed in the genu-pectoral position, the impacted tumour pushed up out of the pelvis, and a large ring pessary adjusted.

[1] Lecture I. was published in THE LANCET of June 6th, 1908, p. 1603.

Drugs.

The treatment of myoma by drugs is unsatisfactory and resolves itself into the alleviation of symptoms. By far the most important of these is hæmorrhage.

Ergot is our chief remedy for the control of the bleeding and in many cases is of great value. It excites the contractions of the uterine muscle, and by pressing together the opposing surfaces of the mucosa checks excessive bleeding. To some extent it also acts by causing contraction of the small arterioles. I know of many cases where patients have taken ergot in drachm doses thrice a day for years and I have never seen it produce ergotism. Its use, however, is not free from objection. As Dr. Thomas Wilson has pointed out, when the heart muscle is degenerated ergot is contra-indicated. It contracts the arterioles all over the body and so increases the resistance to the left ventricle. The liquid preparations of ergot sometimes upset the digestion. In such cases it will be found that ergotin given in pill or tablet form agrees better with the stomach. It may be given hypodermically but there are many objections to this as a regular mode of administration. It is painful, and if not given with aseptic precautions may give rise to small abscesses at the seat of puncture. In emergencies, however, as when a patient is flooding severely and prompt action is necessary, a sterile preparation of ergot given hypodermically is of great value. But beyond controlling the hæmorrhage I doubt if ergot has any good effect on a myoma. The uterine contractions which it excites tend to convert an interstitial fibroid into either a subserous or submucous one. If the latter, whilst it is true that the growth becomes more accessible from the vagina, the tendency to flooding is increased. In any case, I think the prolonged use of ergot predisposes to degeneration and necrosis of the fibroid by interfering with its blood-supply.

Hydrastis is often prescribed with ergot in the form of tablets. It is an astringent to the uterine mucosa and so helps to check the menorrhagia and leucorrhœa due to the endometritis so often present. As far as I know it has no direct effect on a fibroid.

Cotarnine is a derivative of morphia and, in the form of styptol, has been recommended in cases of myoma. I have tried it in several cases but I cannot say I have seen much benefit result.

Calcium chloride has the property of increasing the coagulability of the blood, and in this way favours the natural arrest of hæmorrhage. It is thus undoubtedly of service in bleeding fibroids.

Bromide of potassium, iodide of potassium, and chlorate of potassium have all been advised in myomata but I doubt if any of them do real good. Lawson Tait, following Sir James Simpson's teaching, was in the habit of treating most cases of metritis, subinvolution, and small myomata with chlorate of potassium combined with ergot. He claimed that it was á sedative to the uterus and caused absorption of chronic inflammatory deposits. All the potassium salts are muscle poisons and tend to weaken the uterine contractions. But for the same reason they are also heart depressants and where the heart is failing may do positive harm. Bromide of potassium may be of service in allaying nervous irritability and in promoting sleep. I have never seen any benefit result from the administration of iodide of potassium, or indeed any of the preparations of iodine. I am sceptical, therefore, as to the virtues of the iodine and bromine waters of certain spas, such as Woodhall, Kreuznach, &c. Undoubtedly many patients return benefited from a visit to such health resorts —especially if there was not much the matter when they went. The change of air and scene, the freedom from home worries, the mental and physical rest enjoyed, and the regulation of the patient's diet, bowels, and habits of life—to these factors we must give the credit of whatever improvement takes place.

Tonics.—When a patient is anæmic, weak, and exhausted it is customary to give her tonics, especially iron. Whilst iron picks the patient up and stimulates the blood-forming organs it may prove a dangerous remedy by exciting alarming hæmorrhage from the uterus. It often does far more harm than good. The organic preparations of iron—such as the peptonate—seem to be less hurtful than the inorganic metallic salts. In cases of profound exhaustion it is safer to give strychnine, strophanthus, easily assimilated preparations of phosphorus, and above all the various preparations of hæmoglobin.

Laxatives.—A myomatous woman should keep her bowels well open, as constipation tends to increase congestion of the uterus through scybala pressing on the ovarian veins. Straining at stool may bring on hæmorrhage from the uterus. Further, fibroids frequently cause piles from pressure on the rectum and these as a rule are aggravated by constipation. Some mild laxative, such as cascara, sulphur, compound liquorice powder, or a saline aperient water, should be ordered.

Vaginal Plugging.

Plugging the uterus and vagina is of great help in controlling dangerous bleeding. It may tide a patient over a bad flooding and allow her to gain some strength before undergoing an operation. When called to a patient collapsed, blanched, and nearly pulseless from uterine hæmorrhage it is madness to attempt a big surgical operation such as hysterectomy. The best treatment is to put her on her side, pass a Sims's speculum, and draw down the cervix with vulsella. If the cervix be found dilated the uterine cavity should be firmly plugged with a long strip of iodoform gauze. The first few inches of gauze may be soaked with advantage in a solution of adrenalin. The rest of the vagina should then be firmly plugged with some antiseptic material, such as iodoform gauze or dry boric lint. A firm abdominal binder should be applied to exert counter-pressure on the uterus. The plugging should be removed from the uterus and vagina every 48 hours and fresh material reapplied. In this way the bleeding is controlled and the patient given time to rally. Should the myoma be submucous (and these are the cases in which there is most bleeding) the gauze packing slowly dilates the cervix and renders easy the subsequent removal of the growth. It is most unwise to apply styptics, such as alum or perchloride of iron, to the interior of the uterus to check bleeding. They lead to the formation of hard clots which, decomposing, cause sepsis and precipitate the onset of necrosis.

Electrolysis.

There is a mystery—a glamour—about electrolysis which allures patients who have a horror of the knife and who grasp at any alternative which promises relief. As a means of treatment it has been given a careful trial by scores of gynæcologists and has now been abandoned as futile and dangerous. Vineberg analysed Keith's and Engelmann's statistics, and found that out of 372 cases there were five deaths and only nine cures. Martin and Mackenrodt report 36 cases, of which 16 were distinctly made worse and three died—one from pulmonary embolism, one from necrosis, and one from suppurative peritonitis. In some cases temporary benefit was obtained in the arrest of hæmorrhage from the congested endometrium. But when the treatment was stopped the symptoms returned. In other instances, especially where the electrode was thrust into the growth, acute necrosis of the tumour occurred and endangered the patient's life. It seems to me just as rational to thrust a red-hot poker into the heart of a myoma and expect a cure to result.

II.—SURGICAL TREATMENT.

Bearing in mind the manifold dangers and complications that threaten the myomatous woman, the slender hope there is of a natural cure, and the inadequacy of non-surgical remedies, we are driven to look for help from surgery. I admit it is a choice of evils—no woman wishes to undergo an operation if she can be cured by milder measures. In the early days of abdominal surgery the major operations for the removal of a fibroid resulted in such a frightful mortality that they were only undertaken as a *dernier ressort*. But now, thanks to a more perfect asepsis and an improved technique, modern surgeons can show such a low death-rate that in the great majority of cases a radical operation can be conscientiously advised. Before discussing the merits and demerits of the various operations for myoma, let me briefly state the indications for and against surgical interference.

Contra-indications to operation.—I would not advise an operation: (1) where the tumour is smaller than an orange, is causing no symptoms, and is not growing; (2) where the patient is past the change of life and the myoma is quiescent and causing no trouble; or (3) where the patient is gravely ill from some other condition—such as phthisis, heart disease, or kidney disease—which will of itself prove fatal before long.

Indications for operation.—On the other hand, an operation is called for: (1) where there is severe bleeding, uncontrolled

by rest and ergot; (2) where there is rapid or persistent growth of the tumour; (3) where there are signs of degeneration, necrosis, or malignant disease; (4) in many cases complicated with pregnancy; (5) in cases complicated with gross lesions of the ovaries and tubes; (6) where there are marked symptoms of pressure on the urinary organs; (7) where the tumour is very large and from its great bulk and weight becomes a burden; (8) in some single women where the tumour, from its size, leads to unfounded suspicions of pregnancy and causes the patient much unhappiness; and (9) in cases of sterility due to the presence of a myoma which can be removed without sacrificing the uterus. No hard and fast rule can be laid down. Each case must be considered on its merits and the question of operation decided only after due consideration of the condition of the tumour, its rate of growth, the gravity of the symptoms caused by it, and the state of the patient's general health. The operations for myoma may be divided into: (1) those performed per vaginam; and (2) those that involve abdominal section. Let us first consider the vaginal operations.

Vaginal Operations for Myoma.

Curetting.—Curetting should be performed, after the removal of a fibroid polypus or a submucous myoma, in order to cure the endometritis which generally accompanies these conditions. In some interstitial tumours, if done cautiously and aseptically, it may also do good by checking the leucorrhœa and menorrhagia, and so giving a feeble patient time to regain her strength. It is seldom, however, of more than temporary benefit, and is not without risk. If the tumour be submucous, it may cause necrosis by opening the capsule of the growth and allowing germs to get access to its structure. Further, in cases complicated with pyosalpinx or ovarian abscess curetting may be positively dangerous by the manipulations causing the pus sac to burst into the peritoneum.

Removal of polypi.—A fibroid polypus should be removed as soon as discovered. It is an easy and safe operation. In most cases it is enough to seize it with vulsella and twist it off. If the growth be large and the pedicle broad and vascular it is safer to control the bleeding with a ligature. I usually crush the pedicle with strong Spencer-Wells forceps and then tie a fine silk ligature in the groove left by the forceps. Occasionally a fibroid polypus is met with of colossal size, filling the pelvis and lifting the uterus up into the abdomen. In such cases the growth must be cut away piecemeal before the pedicle can be reached. Patients with fibroid polypi are often quite blanched from long-continued hæmorrhage, but if there be no other complication they make a rapid recovery.

Vaginal myomectomy.—Vaginal myomectomy was first performed by Amussat in 1840. The technique was developed by Atlee, Emmet, and Thomas, and perfected in recent years by Péan and Doyen. It is the operation, *par excellence*, for the removal of submucous growths. These are usually, but not invariably, single. They cause very severe bleeding; and, if of large size, block the pelvis and cause retention of urine. The uterine contractions tend to force the growth downwards, to dilate the cervix, and to convert the tumour into a fibroid polypus. During this process there is a great risk of necrosis occurring. Hence every submucous tumour should be removed without delay. Where the cervix is dilated it is usually easy to enucleate these growths, after the mucous membrane and thin remains of the capsule have been divided. If the cervix be insufficiently dilated it may be split with scissors vertically in the middle line. The growth then becomes accessible and may be removed either whole or piecemeal (*morcellement*). The cervical wound may then be closed with catgut and the uterus preserved entire. It is an ideal method in sterile women anxious to have children, and it is the one always indicated in cases of necrosing submucous fibroids. It is, however, sometimes a long and difficult operation and the patient may lose much blood before it is finished. It is usually unwise to attempt it if the tumour be larger than the fœtal head at term. During the years 1892 to 1908 I find that at the Birmingham Hospital for Women the operation of vaginal myomectomy was performed in 34 cases, with two deaths—a mortality of 6 per cent.

Ligature of the uterine arteries.—This operation was introduced by Dr. Franklin Martin of Chicago, but it has not found much favour in this country. The object is to cut off most of the blood-supply of the uterus, to check the menorrhagia, and cause the tumour to atrophy. But there is such a free anastomosis between the uterine and ovarian arteries that the latter rapidly enlarge, and soon the womb is as well supplied with blood as before. Moreover, a sudden and very marked decrease of the blood-supply may cause necrosis of the growth. It is quite an easy operation. An incision is made in each lateral fornix, the enlarged uterine arteries are felt for, exposed, and tied with stout silk—taking care, of course, to avoid including the ureter. I have performed it in two cases, but without any benefit to the patients.

Vaginal hysterectomy.—The operation of vaginal hysterectomy was first introduced for the treatment of cancer, and is said to have been performed in 1560 by Cruce of Granada, in Spain. Scattered through the surgical literature of the seventeenth, eighteenth, and early nineteenth centuries we find reports of cases by various German, French, and Italian surgeons. Hunter in 1799 was the first to do it in Great Britain, Warren in 1829 in America. The modern operation for cancer we owe largely to the German surgeons—Czerny, Schroeder, Olshausen, Fritsch, and Martin—who, from 1875 onwards, gradually developed the method. On the other hand, for the extension of vaginal hysterectomy to the treatment of myoma we are indebted to the French surgeons, chiefly to Péan in 1883, followed by Doyen and others. It is the best operation to perform in cases of small myomata—other than those which can be enucleated without sacrificing the uterus. It removes the whole of the disease; it does not involve an abdominal scar, and it is attended with but moderate risk to life. In my own practice, hospital and private, I have, up to date, performed the operation for myoma 73 times, with three deaths, a mortality of 4 per cent. It may be a dangerous operation when the uterus, with its myoma, is larger than a three months' pregnancy, if it be fixed by adhesions, if the case be complicated by pyosalpinx or ovarian abscess, or if the vagina be very narrow and rigid. In such cases it is safer to open the abdomen and remove the uterus from above. Some years ago I lost a case by not following these rules. The woman was exhausted by long-continued hæmorrhages from a big submucous myoma. I split open the uterus, enucleated the growth piecemeal, and then removed the rest of the uterus by vaginal hysterectomy. The operation, which took about two hours, was a long, difficult, and bloody one, and the patient never rallied from the shock. Had I opened from above and performed abdominal hysterectomy I feel sure I should have saved her.

Abdominal Operations for Myoma.

We now pass to the consideration of the more important abdominal operations for myoma. These fall under three headings: (1) removal of the uterine appendages (where the ovaries and tubes are removed, but the uterus with the tumour is left behind); (2) hysterectomy (where the tumour, together with most or all of the uterus, is removed); and (3) myomectomy (where the tumour is removed, but the entire uterus is saved).

Removal of the uterine appendages.—This operation was first performed by Lawson Tait in this city in 1872 and to the day of his death he was its leading exponent. It was, *par excellence*, "Tait's operation"; and for nearly a quarter of a century it held the field against all rivals. It was a fairly safe operation when the tumour was a small one, but a risky and unsatisfactory one when it was large. I find that during the years 1882 to 1908 it was performed at the Birmingham Hospital for Women 300 times with 15 deaths—a mortality of 5 per cent. In my own practice I have removed the appendages for small myomata 20 times with one death (a mortality of 5 per cent.), and for large myomata eight times with two deaths (a mortality of 25 per cent.). I have not performed the operation myself since 1896. In about 90 per cent. of the cases that recovered menstruation ceased and the tumour shrank, though I doubt if it ever completely disappeared. But in the remaining 10 per cent. the patient was not cured, the floodings continued, the tumour grew, pressed on the bladder, rectum, and pelvic nerves, and rendered the patient's life a burden to her. Moreover, it was found that even when the operation removed the symptoms due to the myoma it often led to others of a nervous character equally distressing. Such were intense heats and flushes, palpitation, headaches, nervous depression, and pelvic neuralgia. Some of these patients became neurasthenic wrecks. These sequelæ were no doubt due to the sudden cessation of the internal secretion of the ovaries—something which they manufacture, and add to the blood circulating through them, and which is essential to the

well-being of the nervous system. It was these failures and bad after-effects that shook the faith of surgeons in the operation and led them to search for some more excellent way. When it was found that by improved methods we could reduce the mortality of hysterectomy and myomectomy to under 5 per cent. the operation of removal of the appendages was abandoned. None the less should we honour Lawson Tait for his genius in devising this operation and his courage in advocating it. It was at the time a great advance in gynæcology and it saved thousands of lives that would otherwise have been sacrificed.

History of abdominal hysterectomy.—The history of abdominal hysterectomy is interesting and shows by what slow and painful steps the modern operation has been evolved. The successes of to-day have been attained only after years of failure and disaster. Lizars in 1825 and Nathan Smith about 1830 opened the abdomen for supposed ovarian tumours, but finding myomata instead closed the wound without attempting their removal. Clay of Manchester performed the first hysterectomy for myoma in 1843, but his case died. He was followed by Heath in 1843 and Bellinger in 1846, also with fatal results. Burnham in 1853 did the first successful hysterectomy in America. The first successful hysterectomy in Europe was performed in 1861 by Koeberle of Strassburg who invented for the purpose the serre-nœud (or as it is commonly, but wrongly, called the "clamp"). This was an instrument by which the uterine stump was constricted by means of a wire nooze fixed in the lower angle of the wound and allowed to slough away. This extraperitoneal method—improved from time to time by Lawson Tait, Thomas Keith, and J. W. Taylor—was practised for 30 years. It was then displaced by more modern methods, with intraperitoneal treatment of the stump. We distinguish two varieties of intraperitoneal hysterectomy: (*a*) panhysterectomy, or removal of the whole uterus, including the cervix; and (*b*) supravaginal hysterectomy, where the body of the uterus is excised but the cervix is left behind.

Panhysterectomy was first performed by Bardenheuer in 1881 and he recorded seven cases with six recoveries. Mary Dixon Jones in 1888 was the first to do it in America. In this country the first to do the operation was Jessett in London in February, 1892, followed by Smyly in Dublin in the autumn of the same year. I believe I was the first to perform panhysterectomy in the provinces in 1895. In February, 1896, I read a paper before the Edinburgh Obstetrical Society describing the method of procedure and giving details of eight successful cases. Since then the method has been ably advocated by Stanmore Bishop of Manchester and Herbert Spencer of London.

The operation of supravaginal hysterectomy was really first performed in America in 1855 by Kimball, who ligatured and dropped the stump into the abdomen. It fell into abeyance till 1892 when Baer devised the modern operation where, after ligature of the ovarian and uterine vessels, the cervical stump is covered by suturing together the anterior and posterior flaps of peritoneum. This is now the favourite procedure with most gynæcologists and in the hands of such skilled surgeons as Bland-Sutton, Doran, and Haultain is followed by brilliant results.

Extraperitoneal hysterectomy.—The extraperitoneal operation was that always performed by Lawson Tait in those cases in which it was impracticable to remove the uterine appendages. The uterus, with the tumour, was delivered through the abdominal wound, transfixed with steel pins as low down as possible, and strangulated below the pins with an iron wire drawn tight by means of the serre-nœud or "clamp." In some cases a rubber tourniquet replaced the wire. The tumour beyond the pins was then cut away and the wound above it closed. The stump underwent acute necrosis and in about a week became a black, gangrenous, horribly offensive mass. This sloughed off in from 10 to 20 days, leaving a huge gaping septic chasm which took many weeks to close. It was a murderous operation, and those who recovered did so only by the skin of their teeth. They had to run the gauntlet of secondary hæmorrhage, septicæmia, peritonitis, and rupture of the septic wound with extrusion of the bowels. The death-rate was terrible—so great, indeed, that in the annual report of the Birmingham Hospital for Women for 1891 the medical staff announced that they had practically abandoned the operation.

On looking over the statistics of the hospital I find that from 1879 to 1900 extraperitoneal hysterectomy for myoma was performed 58 times with 20 deaths—a mortality of 34 per cent. In my own practice I have done the operation only eight times with two deaths—a mortality of 25 per cent. My last case was in 1895, after which I adopted the intraperitoneal method.

Intraperitoneal hysterectomy.—Under this heading we include: (1) panhysterectomy, where the whole of the uterus, including the cervix, is removed; and (2) supravaginal hysterectomy, where the cervix is left behind. Both methods have their advocates. For some years I clung to panhysterectomy as the better operation. Increased experience, however, has convinced me that in most cases supravaginal hysterectomy is preferable. It is safer for the patient and less difficult for the surgeon. The ureters and bladder are less in danger, the germ-laden vagina is not laid open to the peritoneum, and there is less interference with the integrity of the pelvic floor. The chief argument urged against supravaginal hysterectomy is that the cervix, which is left behind, may become the seat of cancer. But I do not think statistics support this objection. Therefore, contrary to what I taught in 1896, I now hold that, whenever possible, supravaginal hysterectomy should be performed in preference to panhysterectomy. The latter should be reserved for cases where the cervix is involved in the myoma or otherwise diseased. Let me briefly describe the steps of the operation. The first essential is perfect asepsis in every detail. This is far more important than speed or dexterity. The surgeon and his assistant should both wear sterilised rubber gloves over sterilised hands. Instruments, ligatures, swabs, and water are, of course, all duly sterilised. The patient should be placed in the Trendelenburg position and the operating room should have a good top light. The abdomen is freely opened and the uterus, with the tumour, is delivered through the incision. In effecting this Doyen's myoma screw is of great value, especially when the tumour is impacted in the pelvis. The ovarian vessels and the round ligaments on both sides are ligatured with silk and divided. If possible at least one ovary should be saved. The knife is run lightly across the peritoneum, in front of the tumour, above the level of the bladder, and along a corresponding line behind. If there has hitherto been any difficulty in fully delivering the growth it now comes easily up into the wound. The uterine arteries can now be felt pulsating on each side of the cervix. They must be carefully ligatured close to the uterus to avoid the ureters. The cervix is now cut across about the level of the internal os and slightly hollowed out to leave a cup-shaped surface. The muscular tissue of this concave stump is drawn together with a single row of interrupted sutures of fine silk. These suffice to control the capillary oozing. The anterior and posterior flaps of peritoneum are now sutured over the stump. Similarly, the anterior and posterior layers of the broad ligaments are brought together. The result is that, at the close of the operation, there is only a neat transverse seam running across the pelvis. The abdominal incision is closed and the patient put back to bed. It is an easy operation if the patient be thin and the tumour be confined to the body of the uterus. It may be a very difficult one in a fat woman or where the myoma has invaded the broad ligament or developed in the cervix. Whenever possible, one or both ovaries should be left behind, so as to preserve for the patient their "internal secretion." If one or both can be saved removal of the uterus causes practically no climacteric disturbances, whilst if both be removed the patient suffers severely. Of course, if both ovaries be diseased they must be taken away. The after-results of intraperitoneal hysterectomy are excellent. The patient usually makes an uninterrupted recovery and gets up with a soundly healed wound at the end of a fortnight. The mortality of the operation is small. In my own practice, private as well as hospital, I have done 51 panhysterectomies for myoma, with two deaths—a mortality of 4 per cent. I have performed 142 supravaginal hysterectomies, with three deaths—a mortality of 2 per cent.

Abdominal myomectomy.—By this we mean the removal of one or more myomata from the uterus by abdominal section, without removal of any part of the uterus. It was first performed by Atlee as long ago as 1844 but I believe this was only the removal of a pedunculated subserous fibroid. The modern operation (in which the tumours are enucleated from the substance of the womb, followed by suture of the uterine incisions and conservation of the whole organ) we owe chiefly to Martin of Berlin, Olshausen, and Kelly. It is the ideal operation for myoma and will, I believe, ultimately supersede hysterectomy for all but a small minority of cases. It removes the tumour and leaves the uterus intact. It causes no climacteric symptoms and, most important of all, it does

not sterilise the patient. It may, indeed, cure sterility by removing a tumour which was preventing conception or interfering with pregnancy. It may be performed during pregnancy without necessarily interrupting the gestation or adding to the risks of the subsequent labour. In 1891 I was called in to see a case by Dr. Langsford Clay. The patient was aged 37 years and was three months pregnant. She had also two large fibroids which were causing great suffering. She had been married for many years without having been pregnant before and she was very anxious to have a child. I opened her abdomen, made incisions over the tumours, shelled them out of the uterine wall, sewed up the incisions, and closed the wound. The patient made a good recovery. She did not abort but went to term and was safely delivered of a living boy.

I have removed from the one uterus as many as eight separate myomata varying in size from that of a plum to that of the fœtal head. I always use fine silk sutures to close the uterine wounds—in one, two, or three superimposed layers. The success of the operation depends on the care with which these sutures are inserted, on the complete arrest of bleeding, and on perfect asepsis in every detail. Done carefully it is a very safe and satisfactory operation. I have now performed abdominal myomectomy 73 times with one death—a mortality of 1·3 per cent. The operation is as yet only in its infancy, but I am convinced it is the method of the future. Low as its death-rate is now, our aim must be to reduce it to zero.

Here I must draw to a close. Much has been accomplished but more remains to be done. The end of the nineteenth century witnessed a great advance in gynæcology, notably in the treatment of myoma. In the coming years I look forward to still more glorious achievements by our brethren—those workers for humanity seen in the poet's vision—

> "Ever reaping something new:
> That which they have done but earnest of the things that they shall do."

A CONTRIBUTION TO THE BACTERIOLOGY OF CEREBRO-SPINAL MENINGITIS.

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(From the Musgrave Pathological Laboratory.)

PART I.—A GRAM-NEGATIVE DIPLOCOCCUS OCCURRING IN THE FÆCES OF CEREBRO-SPINAL FEVER PATIENTS.

AT the present time, when so much attention is being paid to Gram-negative cocci, a description of an organism of this class found by me on three occasions in the stools of cerebro-spinal fever cases may be of interest.

This organism, though bearing a superficial resemblance to the meningococcus, is quite distinct from it and that it had nothing to do with the meningitis from which the patients suffered was shown by the following facts: (1) typical meningococci were cultivated from their cerebro-spinal fluid; and (2) the blood serum of these cases had a high opsonic index as regards the true meningococcus, but a normal index as regards this organism. The organism is of interest from the fact that its habitat is in the intestine. Tissier[1] in a recent paper refers to two obligatory anaerobic Gram-negative cocci occurring in the stools of young children. To these species the names staphylococcus parvulus and diplococcus orbiculus have been given. The researches of Dunham,[2] Goodwin and Sholly,[3] Gordon,[4] Arkwright,[5] and others have demonstrated the constant occurrence of aerobic Gram-negative cocci in the naso-pharynx, but I can find no reference to their presence in fæces.

Further research may show the presence in the intestine not only of Gram-negative cocci simulating meningococci but also of the meningococcus itself, since the progress of research more and more indicates the intestine as the route by which pathogenic organisms enter the system.

Characters of this Organism.

Morphology.—It is a diplococcus having the coffee-bean appearance of the meningococcus but is somewhat smaller. In broth cultures it appears as ovate diplococci but short chains consisting of four to six individuals are also seen. It entirely fails to retain the dye in staining by Gram's method.

Cultural characters.—On agar stroke cultures appear as a thin film of growth, greyish by reflected, bluish by transmitted, light. Agar plates: surface colonies at the end of 48 hours at 37° C. have a diameter of 5–7 millimetres. They are circular, have an even edge, and are somewhat like meningococcal colonies, but are less raised. The flatness of the colonies renders them more transparent than those of the meningococcus and very much less opaque than those of the micrococcus catarrhalis. The colonies have a curious ringed appearance which may be compared to that presented by a transverse section of a young tree. The deep colonies are of a brownish yellow colour and shaped like a whetstone. The growth on gelatin at 20° C. is good and is very similar to that on agar. No liquefaction of the medium occurs. Bouillon becomes uniformly turbid. No formation of a pellicle on the suface. In litmus milk no acid formation and no coagulation, but bleaching of the litmus occurs. In bouillon containing 1 per cent. of glucose, lævulose, galactose, lactose, maltose, saccharose, mannite, and salicin respectively no acid or gas formation occurs, but instead increase of alkalinity.

The vitality of the organism is good as a subculture can readily be obtained from a culture two months old.

Pathogenicity.—A guinea-pig was inoculated intraperitoneally with the contents of three agar cultures without presenting any ill-effects.

Like that of the meningococcus the growth of this organism on an agar or ascitic agar tube forms a good emulsion with normal saline solution and there is no tendency to clump formation, in these respects differing markedly from the micrococcus catarrhalis. In its absence of acid production in sugar-containing media this organism resembles the micrococcus catarrhalis, but morphologically it is smaller than the latter and culturally the surface colonies are not so opaque. From the meningococcus it is distinguished by its greater vitality, its growth at 20° C., and by the fact that the meningococcus forms acid in media containing glucose. These same characteristics distinguish it from the gonococcus.

The organism is of interest as being an intestinal saprophyte from which a pathogenic parasite might possibly be evolved. That organisms of the same class may be pathogenic is shown by the fact that a coccus somewhat resembling this one was obtained by W. E. Marshall from a case of cerebro-spinal meningitis. J. A. Arkwright[6] gives the following description of Marshall's organism: "On subculture, however, it grew well on agar but always discretely, and the colonies were whiter than those of the meningococcus. It grew in broth, rendering the medium uniformly turbid, and the colonies on agar were not coarsely granular, and were moist and rather sticky. An emulsion was easily made and did not agglutinate spontaneously. In these respects it resembled the meningococcus very closely, but it grew on gelatin at 22° C. without liquefaction; it failed to produce acid from glucose, maltose, or galactose, and an emulsion was not agglutinated by meningococcic serum in dilutions of 1 in 2 and 1 in 10. Moreover, in a film from the original colony the cocci were rather larger and stained better with methylene blue than it is usual for meningococci to do. It is therefore clear that this organism is not the meningococcus. It resembles micrococcus cinereus of v. Lingelsheim in most particulars."

In Part II. a description is given of a case of cerebro-spinal meningitis, in which the infecting micro-organism was very similar to, but not identical with, the one just described.

PART II.—CEREBRO-SPINAL MENINGITIS DUE TO INFECTION WITH AN ORGANISM OF THE MICROCOCCUS CATARRHALIS CLASS.

At the present time cerebro-spinal meningitis and influenza are present in epidemic form in Belfast. It has been shown in a previous communication by Professor W. St. C.

[1] Tissier: Annales de l'Institut Pasteur, February, 1908, tome xxii., No. 2, p. 139.
[2] Dunham: Journal of Infectious Diseases, 1906, Supplement No. 2, p. 10.
[3] Goodwin and Sholly: Ibid., p. 21.
[4] Gordon: Report to the Local Government Board on the Micrococcus of Epidemic Cerebro-spinal Meningitis, &c., 1907.
[5] Arkwright: Journal of Hygiene, January, 1907, p. 145
[6] Arkwright, Ibid., April, 1907, p. 199.

Symmers and myself[7] that the majority of the cases of meningitis are due to infection with the micrococcus intracellularis meningitidis (Weichselbaum). In certain cases, however, we have found that the symptoms were due to infection with such different organisms as the pneumococcus (one case), streptococci (seven cases), the bacillus typhosus (one case), the bacillus enteritidis of Gaertner (one case), and the bacillus anthracis (one case).

The present case is of interest in that the infecting organism was one of the micrococcus catarrhalis class. The clinical history (for an account of which I am indebted to the kindness of Dr. Herbert H. Prentiss, resident medical officer at the Belfast Fever Hospital, Purdysburn) is similar to that of a fulminant attack of cerebro-spinal fever.

The patient, an infant, aged three months, was admitted to hospital at 12.30 A.M. on Feb. 21st, 1908, with a history of an illness of 21 hours' duration. The child was first noticed to have difficulty in breathing; then to become peevish and to cry incessantly. On admission the temperature was 97° F. and the pulse was rapid. The skin was normal except for a few petechial spots on the buttocks. The eyes, the ears, and the throat were normal. There was no rigidity of the neck or of the spine. A slight indication of Kernig's sign was present. The heart and lungs were normal. The lymphatic glands in the posterior triangle of the neck and in the right axilla were enlarged and shotty. The tongue was slightly furred. On Feb. 21st the temperature throughout the day showed a steady rise, being 98·4° F. at 9 A.M., 101° at 5 P.M., 102° at 9 P.M., and 103° at 1 A.M. The child never ceased crying and never slept. There were a petechial rash and mottling over the buttocks, the lower limbs, and the back. The fontanelles were bulging. Lumbar puncture was performed at 3 P.M. and six drachms of turbid fluid were obtained and 30 cubic centimetres of Flexner and Jobling's serum were injected. At 7.20 P.M. convulsions were present, almost all the muscles of the body twitching. The eyes twitched from side to side and up and down. There were frothing at the mouth and vomiting. All the surface of the body except the palms of the hands and the soles of the feet was covered by dark bluish-red patches and blotches which faded on pressure. The pulse was very rapid and weak. Respiration was rapid. Death took place at 2 A.M. Thus the total duration of the illness was about 47 hours.

The lumbar puncture fluid was turbid and there was a large deposit of pus cells. A film made from the deposit and coloured with Leishman's stain showed large numbers of leucocytes and diplococci. Many of these cocci were extracellular and many intracellular, the extracellular staining well, the intracellular faintly. Most of the cells contained granules; some of these cells had the typical appearance of polymorphonuclear leucocytes, in others the nucleus was round and undivided; both varieties, however, were markedly phagocytic. A differential count of 200 cells gave the following result. Granular cells, polymorphonuclear 35 per cent. and mononuclear 59 per cent.; transitional cells, 3 per cent.; large lymphocytes, 1·5 per cent.; and small lymphocytes, 1·5 per cent.

Characters of Organism.

Morphology.—Diplococci having the coffee-bean shape and size of the meningococcus. Short chains of four individuals occur and here and there threads of considerable length which only at their ends show evidence of segmentation into cocci. The cocci, which are quite Gram-negative, stain more uniformly than meningococci, there being few degenerate forms.

Cultural characters.—On agar the organism grows well, the growth being greyish by reflected and somewhat bluish by transmitted light. The growth is more opaque than that of the meningococcus. Subcultures as well as the original culture made from the cerebro-spinal fluid grew well on agar, in this respect differing from the meningococcus which requires the addition of ascitic fluid or serum to enable it to grow when recently isolated. On gelatin at 20° C. good growth occurs without liquefaction. In stab cultures there is a greyish streak of growth along the stab and on the surface a very opaque white colony. On the Drigalski-Conradi medium good growth occurs. This is an important distinction from the meningococcus, the latter showing no growth on this medium. Bouillon and peptone water become uniformly turbid. No indol is formed. In faintly alkaline litmus bouillon containing 1 per cent. of the following substances, glucose, lævulose, galactose, lactose, saccharose, maltose, dextrin, inulin, glycerine, erythrite, adonit, mannite, dulcit, arabinose, raffinose, salicin, sorbit, and amygdalin, no acid was produced but rather increase of alkalinity. The tubes contained a uniform turbid growth with thin iridescent pellicle on the surface. In many cases bleaching of the medium occurred but the blue colour returned when the tubes were left all night at room temperature. In litmus milk the bleaching of the litmus caused the milk to acquire a pinkish shade. Shaking with air brought back the blue colour. No clot formed. Under the anaerobic conditions obtained by Buchner's tubes good growth occurred and no change in colour was produced in neutral red broth. The vitality of the organism was good, as subcultures could readily be obtained after three weeks at room temperature.

Pathogenicity.—A mouse inoculated intraperitoneally with the contents of one half of an agar slope culture collapsed at once and died in 15 minutes. Another mouse inoculated subcutaneously with the rest of the agar culture died in six hours. There is probably, therefore, present in cultures of this organism substances toxic to mice. A guinea-pig inoculated intraperitoneally with the contents of half an agar tube suffered no ill effects.

The opaque and somewhat granular nature of the colonies on agar and the readiness with which the organism grows on this medium, the occurrence of growth at 20° C., and the absence of any acid production in glucose media, distinguish this Gram-negative coccus from the meningococcus and gonococcus. It conforms in most particulars to descriptions of the micrococcus catarrhalis but differs from it in that it shows a tendency to grow in short chains. This organism forms a uniform emulsion in salt solution and does not clump so readily as the micrococcus catarrhalis.

The early death of the patient prevented me from testing the opsonic index of his blood serum with respect to the meningococcus and this organism. The blood serum, however, of a well-marked case of cerebro-spinal fever which was rich in agglutinins and opsonins for the meningococcus gave a normal opsonic index with respect to this coccus.

A brief *résumé* of the history of the micrococcus catarrhalis may be of interest. This micro-organism was originally found by Seifert[8] in sections of lungs of people who had died from influenza. Kirchner (1890) cultivated it from cases in which the clinical diagnosis was influenza. R. Pfeiffer cultivated it from cases of febrile bronchitis and gave it the name micrococcus catarrhalis. Later (1902) Ghon and H. Pfeiffer found it in a large series of cases of epidemic bronchitis. Bezançon and de Jong[9] (1905) and Dunn and Gordon[10] (1905) found the micrococcus catarrhalis in epidemics simulating influenza. It is of interest to note that in the epidemic described by Dunn and Gordon cerebro-spinal symptoms were present in many of the cases and in one case Gram-negative diplococci were found in the meningeal pus, but a culture could not be obtained. In the same year (1905) Davis[11] closely studied the micrococcus catarrhalis. More recently (1907) Arkwright[12] described an organism which had been isolated from the lumbar puncture fluid of a case of cerebro-spinal meningitis and which differed from the micrococcus catarrhalis (1) in that it formed moist and sticky colonies on agar and (2) in that an emulsion was easily made and did not agglutinate spontaneously. Arkwright states that his organism resembles the micrococcus cinereus of von Lingelsheim in most particulars. The organism described in this paper seems to me to be identical culturally with that described by Arkwright; to test absolute identity would require a determination of the opsonic and agglutinative properties of each. Barker (1908)[13] mentions the discovery of the micrococcus catarrhalis in the lumbar puncture fluid in a case of otitic meningitis.

The Gram-negative fæcal diplococcus differs from the present one in being smaller morphologically and in having a flatter and more delicate growth on agar.

In conclusion, my best thanks are due to Dr. A. Gardner Robb, Dr. Prentiss, and to Professor Symmers for giving me every opportunity and facility to investigate this case.

Belfast.

[7] Symmers and Wilson: Brit. Med. Jour., June 22nd, 1907.

[8] Vide article by Neisser in Kolle and Wassermann's "Pathogenen Mikroorganismen," vol. ii., 1903, p. 146.

[9] Bezançon and de Jong (1905): Bulletin et Mémoire de la Société Médicale des Hôpitaux de Paris, vol. xxii., p. 165.

[10] Dunn and Gordon: Brit. Med. Jour., August 26th, 1905.

[11] Davis: Journal of Infectious Diseases, vol. ii., 1905, No. 4.

[12] Arkwright: Journal of Hygiene, 1907, vol. vii., No. 2, p. 199.

[13] Barker: Lumbar Puncture in the Treatment of Otitic Meningitis, Surgical Section of the Royal Society of Medicine, reference in THE LANCET, March 21st, 1908, p. 854.

THE TREATMENT OF INTRACTABLE HAY FEVER AND PAROXYSMAL CORYZA BY RESECTION OF THE NASAL NERVE.

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FOR those cases of hay fever which may be termed "desperate," where all treatment has proved unavailing, where the patient is condemned to an annual period of miserable discomfort and of complete incapacitation, where, it may be, Ossa is heaped on Pelion by the supervention of chronic asthma or other sequelæ, almost any new plan of treatment that is legitimate is, I think, worthy of trial, provided that there are reasonable grounds for supposing the treatment to be capable of giving relief and assuming that the usual recognised therapeutic measures have been fairly weighed in the balances and found wanting. I propose, in the present communication, to describe a new method of treatment which appears to be applicable for these severe and intractable cases and which, up to the present, has given most satisfactory and encouraging results.

The method is based on the theory that the stimulus which induces the reflex manifestations that are observed in hay fever and in paroxysmal coryza[1] is conveyed to the centres by the nasal nerve (nasal branch of the fifth), this nerve therefore being the afferent path of the reflex. If this theory be correct the prevention of the attacks, which characterise hay fever and its congeners, by resecting a portion of the nerve on each side would apparently be possible. The evidence which can be adduced in favour of the theory may therefore be briefly examined. In this connexion there is to be considered, in the first place, the evidence suggested by a consideration of the distribution and the functions of the nasal nerve; in the second place, that suggested by the effects of a particular form of treatment (cauterisation of the nasal mucous membrane); and in the third place that suggested by the effects of bilateral resection of the nerve.

The distribution and functions of the nerve.—Many of the so-called "reflex nasal neuroses" represent an exaggeration or a tendency to precipitation of the normal nasal reflexes. In this category may, for instance, be included the neurosis known as *paroxysmal sneezing*, also that which is designated *paroxysmal rhinorrhœa* where the predominant symptom is reflex hypersecretion from the nasal mucous membrane. It seems not unreasonable to suppose that morbid or exaggerated reflexes of this character usually, although, of course, not invariably, follow the same afferent and efferent paths as the normal reflexes which they represent. Of the *afferent* paths, with which we are at present mainly concerned, for the normal reflexes of sneezing, of vaso-motor turgescence, and of nasal secretion only that for sneezing has, so far as I am aware, been exactly determined. The observations of Wertheimer and Surmont[2] appear to show that the stimulus for the ordinary sneezing reflex is conveyed by the nasal nerve and it may be conjectured that the stimulus which induces the manifestations of *paroxysmal sneezing* travels up the same nerve. The sneezing which sometimes occurs when a beam of bright light falls on the eye is generally considered to be also referable to this nerve, the impulse travelling from the eye *viâ* the ciliary branches. The afferent impulse for the other reflexes, vaso-motor and secretory, which have been mentioned, is usually stated, in rhinological works, to be conveyed by the "nerves of ordinary sensation," without reference to any special nerve being concerned. The nasal branch of the fifth is, of course, not the only sensory nerve of the nasal cavity as there are filaments, principally derived from the spheno-palatine ganglion, distributed to the posterior parts of the cavity. I believe, however, on theoretical grounds, that the nasal nerve conveys the impulse not only for the sneezing reflex but also for the other normal reflexes referred to. Moreover, I think it is this nerve which is also responsible for the convection of the abnormal reflexes which are represented in the condition known as paroxysmal coryza and in hay fever, this conclusion being based on a surer foundation than the foregoing—namely, on the effects observed after division of the nerve.

In the clinical manifestations of hay fever we have, I think, a strong suggestion of the part played by the nasal nerve in relation to this malady; for if the clinical manifestations be considered in relation to the distribution of the nerve, it will be found that they closely correspond in localisation to the areas to which the latter is distributed, and, moreover, that the symptoms would be explicable on the assumption that they represent the reflex effects of irritation of the nerve. It will be recollected that the nasal nerve not only supplies the anterior region of the nasal cavity, but also sends branches to the conjunctiva, the lacrymal sac, the iris, ciliary muscle and cornea, the frontal sinus, the skin of the alæ and the tip of the nose, and the skin of the upper and lower eyelids. Let us take now the characteristic symptoms of hay fever. The initial symptom is usually a sensation of itching at the inner canthus. Following upon this is a feeling of irritation in the nose succeeded by sneezing, nasal obstruction, and hypersecretion. The patient may complain of frontal headache or of a sensation of constriction above the eyes. The eye-symptoms consist generally of congestion of the conjunctiva, lacrymation, and redness and swelling of the lids, and a certain degree of photophobia often supervenes. Usually also there is some redness of the skin at the tip and sides of the nose. The following table gives the symptoms of hay fever, together with the distribution of the nasal nerve:—

Branches of the nasal nerve.	Distribution of the branches.	Symptoms characteristic of hay fever (assumed to represent the reflex effects of irritation of the branches of the nasal nerve).
Internal branch.	Anterior part of septum.	Sneezing. Hypersecretion. Nasal obstruction. Relieved or cured by application of galvano-cautery to anterior parts of nasal cavity.
External branch.	Anterior part of external wall of nasal cavity.	
Infratrochlear branch.	Caruncula lacrymalis. Conjunctiva. Lacrymal sac. Integument of eyelids.	Itching at inner canthus. Congestion of conjunctiva. Lacrymation. Redness and swelling of eyelids.
Branch to frontal sinus.	Mucous membrane of frontal sinus.	Frontal headache.
Anterior branch.	Alæ and tip of nose.	Redness of alæ and tip of nose.
Long ciliary nerves. Branch to ciliary ganglion.	Ciliary muscle, iris, and cornea.	Photophobia.

The effects of cauterising the nasal mucous membrane.—The fact that in many instances benefit may be obtained as regards the hay fever attacks and the paroxysms of vaso-motor rhinitis by the application of cocaine during the attacks, or of the galvano-cautery between the attacks, to special areas in the anterior region of the nose, has been recognised for a considerable time, but the manner in which the beneficial effects are brought about not being evident, the treatment has commonly been regarded as empirical. Nevertheless, the fact that this relief is afforded by cauterising the nasal mucous membrane in the region supplied by the nasal nerve appears to me to be corroborative of the suggestion that the terminal filaments of this nerve represent the starting-point of the reflex disturbances and that the partial or total failure of the latter to be induced, in those cases in which the mucous membrane has been cauterised, is referable to the irritability of the terminal filaments having been diminished or abolished.

The effect of bilateral resection of the nasal nerve.—The strongest evidence in favour of the theory, if *ex post facto* proof may here be considered, is supplied by the effects which have been observed to follow bilateral resection of the nerve. In various forms of vaso-motor rhinitis in which this operation has been performed by me, the symptoms have been completely and, up to the present, lastingly abolished. It may be mentioned that in the first case in which the operation was performed the nerve, to begin with, was divided on the right side only. As a result of this procedure the symptoms—intermittent nasal obstruction with

[1] Paroxysmal coryza (variously termed "vasomotor coryza," "vaso-motor rhinitis," "paroxysmal sneezing," &c.), is a pathological process which is essentially identical with hay fever, differing only in the nature of the exciting cause and the degree of severity.

[2] Wertheimer and Surmont: Les Voies Centripètes du Réflexe de l'Éternûment, Comptes Rendus de la Société de Biologie, 1888, p. 62.

profuse hypersecretion—were abolished in the nasal cavity corresponding to that on which the nerve had been divided, whereas the disturbances continued to recur periodically in the opposite nasal cavity, as before the operation. The sensation experienced when these attacks occurred was described by the patient as a "feeling of the nose being divided in half," one side being clear and the other obstructed. The asthmatic attacks from which the patient suffered also continued to recur at intervals. After section of the nerve on the left side the nasal symptoms entirely disappeared and the attacks of asthma ceased.

The considerations which, in the first instance, suggested that resection of the nerve might be performed with a successful result in severe cases of hay fever and paroxysmal coryza in which other methods had failed, were of course those relating to the functions and distribution of the nerve, &c., which I have already detailed. The following notes of the first case, which was operated upon, will serve to indicate the nature of the procedure and the description of case for which I have felt justified in recommending it:—

The patient, a male, aged 45 years, was first seen in 1907. He complained of asthma and intermittent attacks of nasal obstruction, sneezing and nasal discharge; also, in the summer, of severe attacks of hay fever. He had suffered from hay fever for about 15 years and had had asthma for about the same length of time. The hay fever generally began about the last week in May and continued for about six weeks. During this period he suffered great distress and was quite incapacitated for business. He frequently "wished he was dead." The asthma had gradually become more and more troublesome and he now experienced a bad attack every few weeks with frequent minor attacks in the intervals. In consequence of these he rarely enjoyed a proper night's rest and was often prevented from attending to his occupation. The patient had had treatment from a rhinologist for the hay fever and asthma by galvano-cautery, &c., without benefit to either condition; other methods of treatment had also been tried but no measures whatever had apparently been of any real value. There was a history of rheumatic fever in youth and of expectoration of blood. At the time of examination there was some emphysema, together with cardiac dilatation.

Operation.—Resection of the nasal nerve on the right side was first performed, chloroform anæsthesia being employed. The nerve was reached by an incision at the inner edge of the orbit, commencing just above the inner canthus and extending upwards and slightly outwards for about two-thirds of an inch. The cellular tissue having been cleared from the inner upper wall of the orbit by means of a blunt dissector and the nerve located at the anterior ethmoidal foramen, the latter was separated from the artery and divided close to the foramen, about a quarter of an inch of the nerve being removed. Horse-hair sutures were inserted and the wound was dressed with gauze and collodion. The stitches were removed on the fourth day. Resection of the nerve on the left side was carried out four weeks later.[3]

As I had been unable definitely to promise the patient a cure, or indeed any improvement, on account of the dearth of previous observations relating to the effects of resecting the nerve, I was much pleased when, two months after the operation, he called on me with the information that there had been an entire absence of the attacks of paroxysmal coryza and sneezing and a complete cessation of the asthma. He stated also that he had experienced much comfort and benefit from the increased freedom of nasal respiration[4] and owing to the fact that he was able to insure a good night's rest. He had gained over half a stone in weight since the operation and his appearance indicated a manifest improvement in his general health. The minute scars on the skin were barely discernible even on close inspection. On examining the anterior part of the septum with a probe it appeared somewhat less sensitive than normal, but there was no definite anæsthesia either of this region or of the conjunctiva or the skin.

The effects of the operation in this case were such as to encourage me to perform it in other patients suffering from severe conditions of a similar character. Up to the present the results, as already mentioned, have been of a most encouraging nature, not only with regard to hay fever and paxoxysmal coryza but also with regard to the remaining constituent of the triad, which so often afflicts hay fever patients—viz., asthma. The fact that asthma is frequently associated with the foregoing neuroses and is often relieved by similar therapeutic measures suggests that, at least in some instances, there exists a pathogenetic relationship between the conditions, and the existence of this relationship doubtless explains the relief which has been afforded in my cases.

In conclusion, I desire to point out that the present paper merely constitutes a preliminary communication on the subject, as it would be premature, at any rate as yet, to form any final conclusions as to the permanence of the results obtained by this method of treatment or as to the entire absence of unfavourable effects.[5] Nevertheless, in view of the intractable nature of the maladies for which the operation is suggested I have thought it worth while to publish my observations in their present form for the consideration of those who may be interested in the subject.

Manchester.

[3] In all subsequent cases I have resected the nerve on both sides at the same operation.

[4] Permanent increased freedom of nasal respiration (apart from the immunity from periodical or seasonal attacks of nasal obstruction) has been noted in several of the cases in which this operation has been done.

[5] In a recent case, in which there was some myopia, this appeared to be slightly increased after the operation.

THE GASTROSCOPE.

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GASTRO-DUODENOSCOPY AND DIAPHANOSCOPY.

THROUGH the kindness of Professor Thorkild Rovsing of Copenhagen, who was recently on a visit here, I was enabled to see his gastroscope for electric illumination of the stomach by transillumination and gastroscopy, of which he demonstrated the use on a patient in the Royal Victoria Infirmary, Newcastle-on-Tyne.

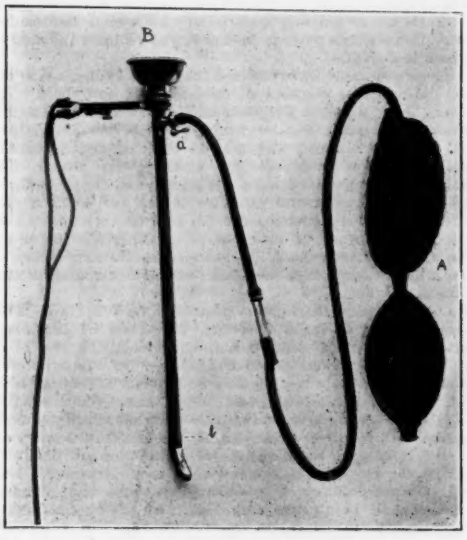
All surgeons must have realised the difficulty in making an exact diagnosis of diseases of the stomach, and these may not be cleared up when the stomach is exposed by operation for thorough examination by ordinary inspection and palpation. Doubt frequently exists as to the pathological conditions that are present—e.g., cases occur where the differential diagnosis between carcinoma and simple inflammatory exudation around an ulcer is not easy—or hæmorrhage from a small mucous erosion may be very difficult to trace to its source; or in cases of multiple ulcers one or more may be overlooked. In such cases Rovsing's gastroscope will be of immense service to supplement other known means of diagnosis.

Rovsing made his first observation on Nov. 7th, 1907. The patient, a woman, aged 50 years, had been ill for three years and was on admission frequently vomiting and in a very wretched and emaciated condition. No tumour could be felt, there was no retention 12 hours after a Bourget test meal, and after a Ewald test meal there was brought up 170 cubic centimetres of lumpy, somewhat slimy stomach contents with free hydrochloric acid 31 and a total acidity of 58. By Roentgen illumination after a pint of bismuth porridge the stomach was found to be much depressed, the small curvature being five centimetres and the greater 11 centimetres below the umbilicus. At the operation the diaphragm was found to be depressed, the edge of the liver reached to the umbilicus, and the stomach was as described. The stomach and six centimetres of duodenum were easily drawn outside of the abdomen; the pylorus admitted the forefinger, and no definite infiltration or thickening of the stomach wall was to be felt. Only on the boundary between the cardiac end of the stomach and the small curvature could a suspicious thickening be palpated. It was impossible to say whether this were only due to a normal fold the stomach wall forms here or to an ulcer. Through a small incision one centimetre long made in the anterior wall of the stomach Rovsing inserted a ureter-cystoscope, to the catheter canal of which he fitted a ball bellows, and making the opening in the stomach air-tight by passing a purse-string suture round the cystoscope he inflated the stomach with air until all the folds of the mucous membrane were smoothed out. As soon as the cystoscope lamp was lighted the whole of the stomach was illuminated like a faintly rose-coloured cupola. All the details in the walls of the stomach could be seen, the muscular fibres, the fine network of veins, &c. A slight

bleeding point close to the incision appeared as a dark red spot from which a small stream of blood was seen to be oozing down the inner wall. No shadows or thinned portions were seen. The mucous membrane was then systematically examined through the cystoscope from the cardiac orifice to the pylorus but no abnormality was found. The cystoscope was next passed through the pylorus into the duodenum, and the posterior wall of the stomach was illuminated by lifting up the omentum and transverse colon. The gastroscopy opening was closed and gastropexy was performed. All the patient's symptoms disappeared. She can now eat any kind of food, has increased in weight by 22 pounds, and is capable of doing her ordinary work.

This case demonstrated clearly that in direct diaphanoscopy and gastro-duodenoscopy a new method of examination had been found which would prove of great value in doubtful cases of stomach and duodenal disease. With the cystoscope which Rovsing first used for this purpose systematic examination of the whole mucosa of the stomach occupied too long a time not only in the interests of the patient but also because it was very fatiguing to the surgeon. He accordingly had made an instrument very much larger than the cystoscope which he calls the gastroscope, and this increases both the strength of the illuminating power and the area of vision which it is possible to see at once. The gastroscope in shape and construction resembles an enlarged Nitze cystoscope, the tube being about four centimetres in circumference, is fitted with a flattened tube along its anterior surface (*a* to *b*, Fig. 1), with a stopcock at *a* connected

FIG. 1.



Gastroscope for diaphanoscopy and gastroscopy. A, Bellows for inflating stomach. B, Gastroscope. *a*, Stopcock. *b*, Opening of inflating tube.

with a bellows (A). With this instrument even an unskilled observer is able to examine the whole of the gastric mucous membrane systematically in a few minutes. The method of use is as follows: (1) diaphanoscopy, and (2) gastroscopy proper—i.e., the inspection of the mucous membrane of the stomach and duodenum.

1. *Diaphanoscopy.*—The stomach is drawn out of the abdomen and a *small incision* fitting tightly round the instrument is made into it through which the gastroscope is passed. If the stomach wall does not fit tightly round the gastroscope a purse-string suture round the incision will make it do so. The stomach is then distended with air by the bellows attached to the gastroscope. The lamp is lighted and (especially if the operating room is darkened) the stomach is seen as a brilliantly lighted cupola. All the anatomical details stand out clearly—the pinkish-coloured wall with the vessels plainly defined, the various layers of the muscular fibres, while the crypts become visible as small white spots on the pink ground. Abnormalities are readily detected—e.g., in gastritis the wall of the stomach becomes a deep pink or a bluish red colour, and the blood-vessels are seen as a close network owing to the dilatation of the smaller vessels. Tumours or growths appear as dark diffused shadows on the otherwise clear wall. The deep chronic ulcer with much surrounding inflammatory exudation and thickening shows as a central excavated or cicatrised portion of porcelain-like whiteness and with but few vessels, and this contrasts strongly with the surrounding pink wall. A small superficial ulcer of the mucous membrane is not easy to discover by diaphanoscopy, but it is easily seen by examination by gastroscopy. A bleeding ulcer, however, can be seen either covered by blood clot as a dark spot in the pink wall, or if actually bleeding a dark streak can be observed trickling towards the larger curvature. It is in cases of this description where even at a post-mortem examination the bleeding mucous ulcer is with difficulty localised that the chief use of diaphanoscopy will be found. Rovsing quotes the following as an instance. On Feb. 17th a woman, aged 38 years, was admitted into the Frederiksberg Hospital. For a month previously she had been suffering from slight dyspeptic attacks, but on the day of her admission she fainted suddenly and showed all the symptoms of profound anæmia. Shortly after she vomited a large quantity of dark blood. On examination in hospital the hæmoglobin was found to be 55 per cent., and in spite of most careful dieting the anæmia and faintings increased. There was constant melæna and on the 29th the hæmoglobin had diminished to 28 per cent. and she was very ill. She was then removed to the surgical wards under Mr. Kraft and two hours later he performed laparotomy. On opening the peritoneum the thin, flabby stomach was pulled out. Neither by inspection nor by palpation was it possible to discover any ulcer. Diaphanoscopy with Rovsing's gastroscope showed upon the otherwise clear and transparent anterior wall of the stomach a small dark spot to which a fairly large-sized artery was seen to pass and suddenly stop. Corresponding to this spot, examination of the mucosa through the gastroscope showed a very small superficial ulceration partly covered by blood clot. Examination of the rest of the mucous membrane of the stomach and of the first portion of the duodenum showed nothing abnormal. The gastroscopy incision was now carried up to where the dark spot had been observed and a superficial ulcer of the size of a pin's head was at once found and when touched began to bleed. Four pairs of catch forceps were then placed outside the ulcer to raise it from the surrounding wall, a ligature was tied round it, and bleeding was stopped. The patient's recovery was tedious but uninterrupted.

It is in most cases impossible to decide by illumination whether a tumour-like infiltration round an ulcer is inflammatory or cancerous, although a dark shadow indicates tumour and a fainter or lighter shadow inflammatory thickening. To inspect the posterior wall of the stomach efficiently by diaphanoscopy the omentum and transverse colon must be lifted up. When the stomach has been thoroughly examined the gastroscope is carried through the pylorus into the duodenum. If there is any difficulty in passing it through it is a sign that the orifice is contracted. The duodenum can be more effectually illuminated than the stomach on account of its thinner walls and smaller size and an ulcer or tumour is easily discernible.

2. *Gastroscopy.*—Simple illumination of the stomach gives a great deal of information; in many cases it allows of a definite diagnosis—gastritis, ulcer, or tumour; in most cases it is an excellent guide for the subsequent gastroscopy, because one immediately makes for the point where abnormal conditions have been shown by diaphanoscopy, and if there is any doubt as to the nature of the disease direct observation through the gastroscope will, as a rule, clear up the difficulty. The picture obtained through the gastroscope is much sharper, better defined, and more certain than that obtained by the naked eye only, for not only is it considerably enlarged and the illumination exceedingly brilliant but the inflation of the stomach causes all the folds of the mucosa to be smoothed out and more accessible to the eye of the observer. It is therefore possible to make a systematic inspection of the entire stomach and the upper portion of the duodenum in a few minutes.

The normal mucous membrane of the stomach appears by gastroscopy as a smooth rose-coloured surface which at the pyloric and cardiac orifices changes into folds of mucous membrane converging as radii towards the circular opening. Any abnormality of these two openings shows itself in a

very characteristic manner: if the pylorus is ring-shaped, infiltrated, and contracted a stiff gaping ring through which a glimpse into the duodenum is obtained is observable; should half of the pyloric ring be infiltrated it assumes the shape of a half moon, the soft mucous membrane of the healthy portion curving into the stiff half of the ring. Any ulcers at the pylorus itself are easily discernible but the folds of the mucous membrane round the pylorus require a closer observation. In the one case where Rovsing had an opportunity of examining an abnormal cardiac orifice the gastroscope gave an exceedingly fine and clear picture of the tap-shaped ulcer projecting into the stomach and the adjoining portion of the mucosa ulcerated.

In cases of ulcer and carcinoma where the diagnosis is clear gastroscopy is of importance because it shows accurately the limits of the disease. It is also useful in clearing up conditions which diaphanoscopy could not—e.g., in several of Rovsing's cases what after other examination was thought to be a simple ulcer, by gastroscopy showed knotty tumour formation in the mucous membrane, and no doubt was then entertained as to the malignant nature of the infiltration. But very important also is the fact that gastroscopy is able to show the presence of mucous ulcers which are not discernible by any other method.

FIG. 2.

Gastroscope for introduction of œsophageal bougie or catheter through the cardiac orifice of the stomach. S, Screw. T, Tongue. C. O., Catheter opening.

The instrument shown in Fig. 2 is oval in contour and in addition to the air-inflating tube contains a tube for the insertion of an œsophageal catheter or bougie. It is fitted like the Albarran ureter-cystoscope with a tongue which by means of a screw can be raised or lowered to direct the bougie or catheter into the cardiac orifice. By means of this instrument a retrograde insertion of a bougie can be made with the greatest ease and under ocular control for the dilatation of œsophageal strictures which are impermeable from above. Being oval, this œsophagus gastroscope requires a purse-string suture round it so that the edges of the stomach incision are air-tight.

Rovsing relates 26 cases in which he has been able to examine the stomach by diaphanoscopy and gastroscopy and afterwards proceed with the operation he then found to be necessary. The use of "cold" lamps in the gastroscope excludes any risk of burning the mucous membrane and a careful inflation of the stomach appears to be harmless. The risk of infection of the wound is overcome by sterilising the whole instrument—gastroscope, wires, tube, bellows—for 36 hours in a formalin steriliser.

Having had an opportunity of seeing the instrument in use it appears to me that Rovsing has placed in the hands of surgeons an instrument of the greatest diagnostic utility and for this reason I am sending these notes to THE LANCET.

Sunderland.

A CASE IN WHICH OCCLUSION OF THE ABDOMINAL AORTA TOOK PLACE.

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COMPLETE occlusion of the abdominal aorta, whether caused by embolus or thrombus, is an event of sufficiently rare occurrence to make the following case worthy of record.

The patient was a man, aged 39 years, who was admitted to the Nottingham General Hospital on May 6th, 1907, complaining of palpitation, shortness of breath, and pain in the region of the heart. These symptoms had been present for 11 weeks. There was no history of rheumatic fever. The patient had had influenza three years ago. His work was very heavy, in an iron-foundry. He was a moderate beer-drinker, and he smoked four ounces of tobacco a week. When he came to the hospital he was of fairly healthy appearance, without obvious cyanosis; the mucous membranes were of good colour, the tongue was clean, and the pulse was 80 and irregular in force and rhythm. The heart's apex was in the fifth interspace, half an inch beyond the nipple line; the impulse was slapping in character. To the right the cardiac dulness corresponded with the right border of the sternum. There was a well-marked presystolic murmur, limited to the region of the heart's impulse, followed by a short first sound. The pulmonary second sound was accentuated. Nothing abnormal was heard in the lungs. The liver and kidneys were normal. There was no œdema of the legs or of other parts.

The patient was kept in bed and he continued to be at absolute rest during the whole of his stay in hospital. A mixture was given containing digitalis and strychnine but the pulse still remained very irregular. The patient complained of some cardiac pain for which a belladonna plaster was applied. His condition was fairly satisfactory until June 17th, when he complained of pain and tenderness in the right iliac region. The temperature rose to 101° F. No swelling could be felt at the seat of pain and in about three days the symptoms had all subsided. On the 23rd the patient complained of pain in the lumbar spine, which during the following night became so intense as to require a hypodermic injection of morphine. Soon after the onset of the pain the patient found that he could not move either leg. When seen on the 24th both lower limbs were found to be completely paralysed in their whole extent. There were absolute anæsthesia and analgesia in front from the lower third of the thighs downwards and behind below the fold of the nates. The knee-jerks were absent. The cremasteric reflex was present. There were scattered patches of dusky mottling on the inner aspect of the thighs, the rest of the limbs being strikingly pale and cold. There was complete absence of pulsation in the femorals, the posterior tibials, and the dorsalis pedis. A trace of albumin was found in the urine. The bladder acted normally. On the 25th the mottled lividity of the skin had increased and the anæsthetic area had extended. The urine was dark-red, containing a large quantity of blood, showing interference with the renal circulation. On the 26th there were constant hiccough and profuse sweating, death occurring at about 6 P.M. No post-mortem examination was obtained.

The diagnosis of so little-expected an accident as occlusion of the abdominal aorta rested on the absence of pulsation in the arteries of the lower limbs and on their condition of coldness and anæmia with patches of livid mottling. Unfortunately, there was no post-mortem examination but I think there can be no doubt that the diagnosis was correct. Occlusion of the abdominal aorta is fortunately an event which very rarely happens. The author of the article on the

condition in Allbutt's "System of Medicine"[1] was able to collect reports of 59 cases, all of which excepting three were fatal. Considerable doubt is permissible as to whether the arrest of the circulation is caused by embolism or by thrombosis. Valvular disease of the heart, especially mitral stenosis, is a fruitful source of embolism, hence it is natural to suppose that embolism of the aorta should occur in the same circumstances as embolism of smaller arteries. The large size of the aorta raises the doubt whether any embolus could be sufficiently large to completely plug it. But an embolus frequently grows in size by the formation of thrombus around it and therefore an embolus arrested at the bifurcation of the aorta might be enlarged in this manner until it filled the lumen of the vessel and extended into both iliacs. The attack of pain in the right iliac region which this patient experienced a few days before the final attack may have been due to a similar cause, whether embolism or thrombosis. The occlusion in this instance cannot have been complete as the symptoms associated with it abated, yet it seems not improbable that an embolus was carried into the right internal iliac, still allowing the circulation to be carried on for a time, and that by gradually extending upwards it eventually caused the obstruction of the aorta. In 34 per cent. of the cases collected by Welch[2] mitral stenosis was present. Mitral stenosis not only provides a possible source of embolus but also often leads to very low arterial blood pressure, which itself is a cause of spontaneous clotting in the vessels. In my patient compensation had quite broken down and it was found impossible by means of rest and cardiac tonics to restore regularity to the pulse or tone to the heart. Hence the circulation was inefficiently maintained, the propulsive force being weak and intermittent. Under these conditions thrombi might very readily be formed in the left cavities of the heart and be the source of an embolus, or it may be that owing to comparative stasis of the circulation primary thrombosis of the aorta or internal iliac occurred. Sometimes the thrombosis is due to extensive atheroma, as in the case reported by the late Mr. W. H. Brown of Leeds.[3]

Whatever the exact pathology of the case the occlusion was evidently complete. The clot probably reached as high as the renal arteries, and this grave interference with the circulation, together with the co-existent cardiac disease, was sufficient to bring about a very rapid termination. But death does not always occur so quickly as in this case. It may be deferred days, weeks, or even months, and be due to gangrene, sepsis, or general exhaustion.

The paraplegia which attends occlusion of the abdominal aorta is doubtless due to the shutting off of the blood-supply. But whether it depends on anæmia of the spinal cord or of the peripheral nerves and muscles is not decided. It is important, therefore, that careful examination of the cord should be made whenever possible.

Nottingham.

THE TREATMENT OF GANGRENE IN STRANGULATED HERNIÆ AT ST. THOMAS'S HOSPITAL, 1901–1905.

BY EDRED M. CORNER, M C CANTAB., F R.C.S. ENG.,
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IN the St. Thomas's Hospital Reports of 1900 I published a paper[4] in which was set forth the condition of the bowel found in the strangulated herniæ admitted to the hospital during the ten years 1891–1900. In the present note I wish to direct attention to but one part of the subject of this original communication—the treatment of necrosis of the bowel in strangulated herniæ. Since 1900 there have been far more instances of necrosis of the bowel recognised in these cases, giving therefore a better estimate of the present-day treatment than was the case in my original communication. The occurrence of an infective necrosis of the bowel[5] has now been recognised and has led to the more frequent recognition and treatment of the damaged bowel found in strangulated herniæ. In the five years from 1901–1905 necrosis of the bowel has been recognised and treated 30 times, as compared with 42 in the ten preceding years.

Resection and immediate anastomosis.—The balance of the treatment adopted has been in favour of resection and anastomosis of the bowel whenever possible. 18 of such cases have been done with eight recoveries, a recovery rate of 45 per cent. and a mortality of 55 per cent. Thus a great advance has been made on the condition of affairs at the time of the publication of my paper in 1900, when the mortality for the resection of the bowel and anastomosis in gangrenous strangulated herniæ was 80 per cent. It is on account of this very great improvement that I decided to publish this note now, after five years, rather than await the lapse of a decade. There are several reasons which have contributed to this improvement. Firstly, instances of early gangrene or necrosis have been recognised and treated. Secondly, cases where the bowel was only "doubtful" may have been excised, though this must have been infrequent. Thirdly, there are the improvements of modern technique, such as the removal of the bowel widely above the obstruction. A further point of interest is that those cases where the resection of the bowel has been followed by an end-to-end anastomosis, circular enterorrhaphy, have done better than when a lateral anastomosis has been employed.

Resection and enterostomy.—In the same period, 1901–1905, there have been ten cases in which the resection was followed by the making of an artificial anus, an enterostomy, from which there has been only one recovery; recovery rate 10 per cent., mortality 90 per cent.—a result which agrees very closely with the previous finding in 1900, when the mortality was 88·9 per cent. There is certainly one great contributory factor in producing this more or less stationary condition of affairs, which is that the treatment by resection and enterostomy has been reserved only for the very worst cases. Yet in spite of modern advances there has been no improvement in the results. During the same period there has been a diminution by 35 per cent. in the mortality of those cases treated by resection and anastomosis of the bowel. There can be no doubt along which line of treatment modern surgery will progress—resection and anastomosis.

From a surgical and philosophic point of view this is very remarkable, because there is hardly any point upon which abdominal surgeons are so unanimous as that it is far safer to do an anastomosis on healthy bowel than on bowel distended with septic fluid such as it is in intestinal obstruction, an enterostomy at the time and a subsequent anastomosis yielding far better results. Yet in the case of strangulated herniæ the trend of modern opinion is in the opposite direction. There should be a reason for this and I would urge that there probably is a difference in the septicity of the bowel and its contents in cases of intestinal obstruction which have been acute from the beginning, as in the strangulation of a hernia, and when the acute obstruction has merely been imposed on a chronic, as when due to carcinoma of the sigmoid. In the former case the septicity is localised to the vicinity of the obstruction, so that if the resection is done freely more or less healthy tissues will be sutured and success will be attained. And in the latter case the septicity extends further afield and all plastic operations, like anastomoses, are done in a septic area and end in disaster. Then the surgeon, in order to make a successful anastomosis, must either resect so extremely widely that the magnitude of the operation will probably kill a patient, who is already ill, in order to get away from septic bowel and contents, or he must do an enterostomy and having waited for the bowel to have become cleansed and all "endo-enteritis" to have subsided, perform his anastomosis on healthy tissues. This may be the explanation for the very different clinical results obtained by anastomoses made in varieties of intestinal obstruction.

Invagination.—Besides resection with anastomosis or enterostomy two cases have been treated by the invagination of the gangrenous or doubtful area. Both patients recovered and the cases were most successful. The method is obviously applicable only to small areas of necrotic bowel, and in practice will be mainly useful for secluding "doubtful" bowel. But these two cases show that its judicious application has a useful, if not a large, field in the treatment of necrosis of the bowel in hernia. It may be suggested that it is useful at times at the place where the bowel has been "nipped" and also for the patchy gangrene sometimes found at the apex of the strangulated loop. But

[1] Vol. vi., p 273.
[2] Loc. cit.
[3] Transactions of the Clinical Society of London, 1893.
[4] Gangrene in Strangulated Herniæ, &c., St. Thomas's Hospital Reports, 1900.
[5] Clinical Pathological Observations on Acute Abdominal Disease. Constable and Co. 1905.

the dependence of the necrosis on the action of organisms places a bar upon the extended employment of this method which is likely to be more useful as a safeguard for "doubtful" bowel rather than when gangrene or necrosis has already declared itself.

Mortality.—In 1900 the mortality for the herniæ in the different regions was given. Of umbilical herniæ it was said: "For complicated strangulated herniæ they have the highest mortality of all. A quarter of the cases contain gangrenous bowel." These statements are borne out by the cases in the subsequent hemidecade: of ten cases, only two patients recovered; mortality, 80 per cent. Of strangulated femoral herniæ it was said "a fifth contain gangrenous bowel." Out of 12 cases, four patients recovered; mortality, 66 per cent. Of inguinal herniæ it was said, "generally speaking, they are of much better prognosis than any of the other varieties." A twentieth of the cases admitted contained gangrenous bowel. Of eight cases, five patients recovered; mortality, 37 per cent. Hence it may be said that the cases of 1901–1905 bear out in the more modern treatment all that was said of the different varieties of hernia in 1900.

St. Thomas's Hospital Cases, 1901–1905.

	Mortality.
Complicated strangulated inguinal herniæ	37 per cent.
" " femoral "	66 "
" " umbilical and ventral herniæ	80 "
Of 216 strangulated inguinal herniæ gangrene was recognised in 8	3·6 per cent.
Of 133 strangulated femoral herniæ gangrene was recognised in 12...	9 0 "
Of 46 strangulated umbilical and ventral herniæ gangrene was found in 10	21·7 "

The figures support the contentions made in the previous paper in general, though not entirely in detail. The former percentages for 1891–1900 were 6·1, 19 5, and 25·4 respectively.

Harley-street, W.

A CASE OF DISSECTING ANEURYSM OF THE PULMONARY ARTERY; PATENT DUCTUS ARTERIOSUS; RUPTURE INTO THE PERICARDIUM.

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AND

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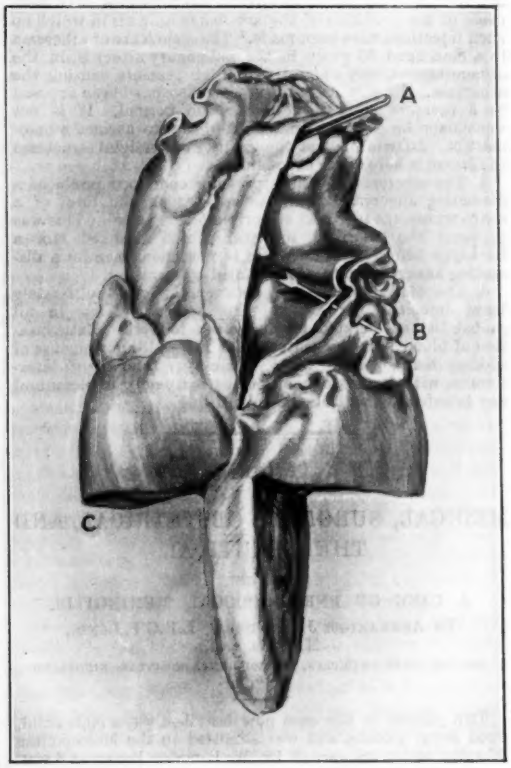
ANEURYSMS of the pulmonary artery are common enough within the lung as the result of cavity formation in phthisis. But aneurysms of the artery before the lung is reached are very rare. According to Crisp[1] two cases of aneurysm of the main branches were reported in England between 1785 and 1847. He says: "I know of no case of aneurysm of that artery before its division." Dlauhy[2] described a case in 1848. Gilewski[3] found a saccular dilatation of the main trunk as large as a pomegranate. Dowse[4] met with a case of ruptured aneurysm in a girl, aged 19 years; the sac was filled with clot and as there were vegetations on the pulmonary valves it is probable that this was mycotic in origin. Skoda's work on "Auscultation and Percussion" contains an account of an aneurysm of the trunk of the pulmonary artery as large as a goose's egg. Duffield's[5] case of pulmonary regurgitation with aneurysm of the right and left pulmonary arteries resembled ours in the fact that the aneurysm was dissecting in character and had ruptured into the pericardium. It differed in the important particulars of being associated with a lesion of the valve and of beginning in the right branch. Sansom's article in the "Twentieth Century Practice of Medicine"[6] quotes also a case of Crudeli's where there was a general dilatation of the pulmonary artery with small saccular aneurysms above the semilunar valves, one of Sir Dyce Duckworth's associated with congenital malformation of the pulmonary valves, and one of Bruen's associated with congenital malformation of the heart. These are all the instances that we have come across in the literature of the subject.

The patient was a groom, aged 33 years, who appeared to have good health generally. But latterly he had complained that on running a horse he would get out of breath much sooner than usual and had a stuffy feeling in the chest. On severe exertion he would get dusky in colour. Beyond these complaints he was quite able to do his work; he was the father of four children, all healthy. About a fortnight before he died he was attacked with severe pain in his chest and vomited. The medical man who attended him put this condition down to gastritis and treated him accordingly for a fortnight, when the patient declared himself able to resume work. This he did for one day. In the night following that day his wife was awakened out of her sleep by his making noises as if struggling for breath. On trying to give him something to drink she found that he was dead. One of us saw him soon afterwards—about 5.30 A.M.—and found him lying in bed in quite a natural position. The medical man who attended him previously to his death could throw no further light on the subject.

We made a post-mortem examination on the same afternoon. On opening the chest the pericardial sac was found to be distended with about a pint of dark clotted blood. A small hole was found in the pulmonary artery about one and a half inches from its origin, close to the left auricular appendix. The right ventricle was much hypertrophied, the maximum thickness of its outer wall being seven-eighths of an inch (after hardening in formalin), while the maximum



The dilated pulmonary artery is laid open, showing the patches of atheroma. The rod A is passed through the patent ductus arteriosus, close to which a small saccular aneurysm is seen. Under the arrow a tear in the wall of the artery can be seen, starting from the right branch of the pulmonary artery and rupturing into the pericardium close to the head of the arrow at B. The ventricular walls have been cut away so as to expose the great thickness of the right side, which can be seen at C.

[1] Diseases of the Blood Vessels, 1847, p. 91.
[2] Quoted by Dowse, vide infra.
[3] Wiener Medicinische Wochenschrift, Nos. 33–38, 1868.
[4] THE LANCET, Nov. 7th, 1874, p. 660.
[5] American Journal of Medical Science, Philadelphia, 1882, N.S., vol. lxxxiii., pp. 77–82.
[6] Twentieth Century Practice of Medicine, vol. iv., pp. 527–538.

thickness of the left side was half an inch. The ductus arteriosus was widely patent, its walls being atheromatous. The pulmonary artery and its two main branches were dilated uniformly, the walls showing large plaques of atheroma. Just before the ductus arteriosus was reached there was a little saccular aneurysm about as large as a filbert. At the bifurcation of the pulmonary artery into its two divisions the intima and media were torn right through. A dissecting aneurysm had formed which contained a small amount of blood clot. This aneurysm had burst into the pericardium. All the other viscera were greatly congested, but no other lesion could be found, except that perhaps the capsules of the kidneys were slightly adherent.

Remarks.—The sequence of events would seem to have been as follows:—

1. The patency of the ductus arteriosus made it necessary if the pulmonary circulation was to be duly maintained for the pressure in the right side of the heart to rise till it was equal to that of the left. Therefore the right ventricle was compelled to hypertrophy. Normally the pressure in the aorta is about 150 millimetres of mercury, while that of the pulmonary artery is only 60 millimetres; consequently the resultant hypertrophy was very considerable.

2. The artery became atheromatous. Whether high pressure is a cause of atheroma is a disputed point. The experimental production of atheroma by injections of adrenalin has been held to prove this, but it seems doubtful whether sufficient control examinations have been made of the condition of the arteries in animals in which no such injections have been made.[†] The occurrence of atheroma in a man aged 33 years in the pulmonary artery is, in the circumstances, very suggestive of high pressure causing the atheroma. In this case the vessel must have been exposed to a pressure more than double the normal. It is not uncommon for a patent ductus arteriosus to become atheromatous. Darwin's law of the liability of vestigial structures to disease is here again exemplified.

3. The atheroma and high pressure combined produced a dissecting aneurysm which, as usual, took the form of a sharp transverse tear near the origin of the vessel. This was probably the cause of the pain which attacked him a fortnight before his death. It is not uncommon for a dissecting aneurysm to be accompanied by vomiting.

4. The blood extravasated between the coats ultimately burst into the pericardium, this accident being in all probability accelerated by his return to work. Extravasation of blood into the pericardium is a well-known cause of sudden death, for the heart, while very tolerant of interference with its systolic output, is extremely intolerant of any interference with its diastolic filling.

† Miles: Journal of the American Medical Association, Oct. 5th, 1907.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF PNEUMOCOCCAL MENINGITIS.

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THE patient in the case now described was a male child, aged seven months, and was admitted to the Metropolitan Hospital under the care of Dr. W. Langdon Brown at 6 P.M. on May 9th, 1908. The mother brought him because she had noticed that "since May 3rd the child had seemed a little off colour and that on the 9th the child appeared to have pain in the back whenever he was lifted up." The mother had had an easy labour at the birth of the child who was carried to full term and was breast fed. He suffered from bronchitis at the age of six weeks and from chicken-pox at the age of five months, but never had any discharge from the ears. The family history had no bearing on the illness. On arrival at the hospital the child was found to be well-nourished and was not crying. The fontanelle was widely open, very tense, and bulging. The child was not blind; the pupils were equal and reacted to light. There was an external squint of the left eye. The ears appeared to be natural and there was no discharge from them. The chest was natural; the abdomen was also natural, being neither distended nor retracted. The abdominal reflexes were obtained on both sides. The legs were very rigid; the knees could only be flexed with difficulty and the thighs could scarcely be flexed at all. Kernig's sign was therefore not obtainable, since the thighs could not be flexed even when the knees were already flexed. The plantar reflexes were extensor on both sides. Lumbar puncture was performed on admission, one test-tube full of clear fluid being withdrawn. Chemical examination showed that this fluid contained reducing sugar and much albumin. On microscopical examination 330 leucocytes per cubic millimetre were found, the majority being polymorphonuclear. Cultivation on serum agar gave in 18 hours a growth of a Gram-positive diplococcus. On the next day the child had fits which continued until his death at 2.30 on May 11th. His temperature at the time of death was 105·6° F. A second lumbar puncture was made just before death; the fluid then withdrawn was turbid and yielded a pure culture of the pneumococcus.

At the necropsy the body was seen to be well developed. In the skull a little pus was present on the internal surface of the dura mater in several places at the vertex and at one spot opposite the pole of the left temporo-sphenoidal lobe. At this spot the dura mater was roughened but on peeling it off the bone appeared to be quite healthy, as indeed it appeared to be everywhere. Both of the internal ears contained a little viscid mucus but no pus. In the brain a thick layer of greenish-yellow pus could be seen under the arachnoid covering the whole of both frontal lobes and extending backwards on to both parietal regions. Behind the fissures of Rolando the pus lessened in amount and was only present in small scattered patches on the parieto-occipital regions. Both temporo-sphenoidal poles were covered with pus, which also filled the Sylvian fissures. At the base the pus was situated in and around the interpeduncular space and optic chiasma. The arachnoid covering the pons was only slightly opaque while that over the medulla oblongata was unaffected. The blood-vessels behind the pus-covered area were considerably congested. The convolutions on the surface were much flattened but the brain was not cut into as it was preserved entire. The spinal cord appeared to be natural; a little pus was present outside the dura mater in the dorsal and lumbar regions but there was none within the membranes. All the other organs in the body appeared to be natural.

In a paper published in THE LANCET of Oct. 8th, 1904, p. 1017, by Dr. A. T. Davies and Dr. Langdon Brown, I see that it is said: "Probably not pneumonia only but all pneumococcal infections tend to be septicæmic. Thus at St. Bartholomew's Hospital during the last ten years 17 cases of meningitis without discoverable lesion elsewhere were proved to be pneumococcal. In three instances cultures of the spleen yielded a pure growth of pneumococci." In the present case it seems to me that this child must have had a septicæmia. It is unthinkable that the meninges could be the only, or even the primary, seat of infection.

I am much indebted to Dr. Langdon Brown for permission to publish these notes, and also to Mr. Ernest H. Shaw, pathologist to the hospital, for help in the bacteriological and post-mortem work.

Metropolitan Hospital.

NOTE ON A CASE IN WHICH THE WIDAL REACTION PERSISTED SEVEN YEARS AFTER AN ATTACK OF TYPHOID FEVER;

ASSOCIATED WITH SUPPURATIVE CHOLANGITIS, TYPHOID BACILLI BEING FOUND IN THE BILE PASSAGES.

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THE patient came into the Derbyshire Royal Infirmary suffering from jaundice and periodical attacks of shivering. She had been ill for five weeks and the trouble began with a paroxysm of intense pain, which was diagnosed at the time as gall-stone colic. Since that time she had wasted steadily and lost strength. There was no history of diarrhœa. She had had typhoid fever seven years before.

On admission the patient, who was a stout, somewhat flabby woman, had a temperature of 101·4° F. and a pulse-rate of 132. The respirations were 32. She was very listless,

lay flat on her back, and was distinctly jaundiced. The tongue was dirty and very dry, and the abdomen, though not tender on palpation, was distended. The liver was enlarged, the lower edge being depressed fully three fingers' breadth below the costal margin. No irregularities could be made out on its surface. The spleen could not be felt when she was admitted but it became palpable on the fifth day. There were no rose spots. The heart was dilated and no apex impulse was visible or palpable. The area of cardiac dulness extended fully an inch to the left of the left nipple line. To the right, dulness extended half an inch to the right of the sternum; above it reached to the top of the third rib. A marked canter rhythm was heard all over the cardiac area, the first sound being accentuated and the second reduplicated. This rhythm was most evident at the apex. Ten days after admission the reduplication of the second sound disappeared, its place being taken by a soft systolic murmur conducted outwards into the axilla. The breath sounds were normal in character and there was no evidence of consolidation anywhere. Moist sounds were audible over the bases.

On the day after admission the temperature rose to 102·8°, and for the next five days it varied between 98° and 100°, the daily excursions being remarkably uniform. On the sixth day it rose to 101·8° and fell gradually to the normal during the next two days. On the eleventh day it was 101·2°, falling to 99° on the next morning; on the evening of this day it rose to 102° and fell to 98° on the day following. On the day on which death occurred it rose to 103°, dropping immediately to 96·8°. The cardiac dilatation rapidly subsided with the rest in bed and the pulse became more regular. During the first eight days it varied between 132 and 116; then it became steadier and ranged between 80 and 60. The patient, however, did not show any improvement in her general condition, but became more and more asthenic. Throughout the whole of the time that she was under observation in the hospital this was a very marked feature of her condition; she did not show the improvement in her general state that might have been expected from the physical signs. Constipation was obstinate all the time that the patient was in the hospital, the stools being clay-coloured. The urine contained neither albumin nor bile. During the last two days of life persistent and intractable vomiting set in, the patient not being able to keep even albumin water in her stomach. From the day of her admission there had been mild delirium at night and this became intensified during her last few days. Death occurred on the fourteenth day after her admission.

On opening the abdomen post mortem the first object that attracted attention was the liver, which was enlarged and studded with brownish-yellow nodules that fluctuated on pressure. On closer examination the great omentum was found to be adherent to the gall-bladder and could only be detached by tearing this latter structure. On section a thick creamy substance of a bright orange-yellow colour oozed from the bile-ducts, which were thickened and distended. This was universal over the whole organ. The contents of the gall-bladder were normal in colour and the ducts did not show any stenosis; the gall-bladder contained a gall-stone. The liver weighed five pounds. There were no typhoid lesions found in the intestines; the spleen was somewhat enlarged. The other organs were normal, there being no signs of endocarditis. The pus, taken from the intrahepatic bile-passages, showed both culturally and on films the presence of the bacillus typhosus in large numbers.

I have ventured to record this case as possessing some interest not only on account of the patient's probable rôle of a typhoid carrier, but also because it also shows that the Widal serum reaction may persist as long as seven years after the attack of typhoid fever. Professor Hewlett, in his "Text-book on Pathology," states that "the reaction of agglutination once acquired, may persist for years—certainly three or four." In this case there was a most clear and convincing account of typhoid fever seven years before the patient was admitted into the hospital, and the reaction was accountable for a not unnatural difficulty in the diagnosis. The patient was admitted as a case of typhoid fever, and yet there were not many symptoms, apart from the serum reaction, which pointed to this disease. The enlarged liver and jaundiced aspect at first gave rise to the idea that she was suffering from cholangitis, with the possibility of ulcerative endocarditis; when, however, the result of the serum reaction became known we considered it to be, and treated it as, a case of typhoid fever. Nevertheless, we realised that there were many atypical symptoms, and we were not altogether satisfied with this diagnosis. Had we known that it was possible for the serum reaction to persist for seven years after the attack which gave rise to it, I do not think that we should have held to this diagnosis at all.

The second point of interest shown by the case is one which has had a great deal of attention directed to it lately—namely, the danger to a community from having such a patient as this in its midst. This woman must have been discharging typhoid bacilli more or less continuously for seven years, and recent evidence has conclusively proved that her case was in no way unique. The early recognition of such cases appears to be imperative in any crusade against typhoid fever, and it would be instructive to know what connexion, if any, a persistent Widal reaction has with persistence of typhoid bacilli in the organism.

I am indebted to Dr. M. Parry-Jones for giving me permission to publish this case.

Derbyshire Royal Infirmary.

Reviews and Notices of Books.

Comparative Anatomy of Vertebrates. Adapted from the German of Dr. R. WIEDERSHEIM by Dr. W. N. PARKER. Third edition. London: Macmillan and Co. 1907. Pp. 576. Price 16*s.* net.

THE last English edition of this book appeared in 1897 and was based on Professor Wiedersheim's "Grundriss der Vergleichende Anatomie der Wirbelthiere." There has been an interval of ten years, therefore, between the publication of that edition and the appearance of the present volume which is adapted from the "Grundriss" of 1906 and, as may be supposed, the growth of our knowledge of comparative anatomy during those ten years has made it necessary, even with the most careful condensation, to increase the size of the work by nearly 100 pages.

The introductory chapter gives a definition of the various minor branches which make up the complete science of comparative anatomy. We are glad, by the way, to see the old-fashioned name retained because, though many modern animal morphologists are inclined to look down upon it, comparative anatomy has a very real meaning apart from old associations and has never been adequately replaced by any other name. A brief outline of the chief details of embryology succeeds, followed by a general review of the chief organs and systems of the vertebrata. This is illustrated by a diagrammatic scheme of a sagittal section of a generalised vertebrate, which is new and would be more valuable if the duodenal loop were directed ventrally instead of dorsally and the spleen placed in the dorsal instead of the ventral mesentery. Moreover, the pancreas might have shown one or more ducts in the same way that the bile-duct is shown. The classificatory and palæontological tables remain as in former editions and are most valuable for reference.

The chapter on the integument has several new and useful process illustrations, but it is doubtful whether it would not have been more convenient to treat it and the exoskeleton together; at any rate, we cannot agree with the author when, on p. 43, he includes the abdominal ribs of Hatteria (now usually known as Sphenodon) and of the crocodile among exoskeletal structures. Again, on the next page he says in a footnote that the mammalian sternum may include some vestiges of the exoskeletal episternum. If he does this he should surely be consistent and give mammals credit here for having exoskeletal vestiges in the roof of the cranium and bones of the face, as well as in the sternum. We should like to know why the author casts a doubt on the perfect homology of the intercentra of mammals with those of other vertebrates. Boulenger has shown how common they are in lizards, while similar traces can be found in many mammals. Unless the author denies the serial homology of these structures with the ventral arch of the atlas he is

practically throwing out a suggestion that the ventral arch of the atlas in mammals is not homologous with that of reptiles and birds, yet he says on p. 62 that the atlas and axis of mammals essentially resemble those of birds.

In the skull some excellent new illustrations are added and the chapter forms a good and clear introduction to the study of this difficult subject. The limb bones, too, are fairly dealt with except that we look in vain for some discussion on the very important question of the nature and uses of epiphyses; indeed, in the index, epiphyses of long bones are not even mentioned. On p. 172 it is stated that the patella is in no way comparable to the oleolecranon (*sic*) of the ulna as was formerly supposed. This appears to us a drastic statement and one on which we should be grateful for some reasoning. It certainly is opposed to some modern research which has not been noticed.

The nervous system has been well overhauled and the enormous literature on the pineal region and nerve components has been done as much justice to as space would permit. We notice, however, that one page is still all that is allotted to the spinal cord and that few additions to the description of this region have been made with the exception of a footnote on Reissner's fibre. The vascular and genital apparatus are done ample justice to, but so far as their embryology is concerned cannot be said to be well up to date. The omissions, however, are seldom of first-rate importance.

The appendix on the literature of the subject is a most valuable part of this book and is as exhaustive as can fairly be expected when the size of the work is considered. There are, it is true, several modern papers which might with advantage have been added even at the expense of leaving out some of the older ones, because these are always referred to in the newer. We think that it would aid reference if the names of the subjects with which the papers deal—e.g., skull, nervous system, and so on—were printed on the top of each page, and perhaps this suggestion may be adopted in subsequent editions.

We have no hesitation in commending this book to teachers and to students alike. It is well written, well got up, and abundantly illustrated. The immense mass of facts is digested and arranged with a master's skill, and, if the work tends to err on the side of too dogmatic statements, it is a fault which the student will be thankful for and the research worker will view with a very lenient eye, for, in the present stage of morphology, to day's nay is often to-morrow's yea.

The Cradle of the Deep, an Account of a Voyage to the West Indies. By Sir FREDERICK TREVES, Bart., G.C.V.O., C.B., LL.D., Serjeant-Surgeon to H.M. the King. With numerous illustrations and one coloured plate. London: Smith, Elder, and Co. 1908. Pp. 374. Price 12*s.* net.

IN certain of the natural gardens of the West Indian archipelago there is to be found a tree of such extreme beauty as to attract the traveller's notice amongst a confusion of splendid rivals. Its leaves are of an exquisite green and graceful shape and it is thickly hung with bright scarlet globes which when they have ripened afford a wholesome food of delicate flavour. This is the akké fruit which has one peculiarity, that beneath its outward beauty, before the ripening process is complete, there lurks a sufficient amount of prussic acid to kill the man who unwarily partakes of it. The akké tree stands as a fitting type of the lands that give it nourishment, lands of a transcendent fairness which has captivated the imagination of travellers since first they broke upon European eyes, and which has yet formed the background for manifestations of cataclysmal cruelty of nature and of murder, rapine, and lust of man, such as perhaps the history of no other region in the world can equal.

The latest addition to the many books of travel which seek to set forth the wonder and the tragedy of the West Indies is from the pen of Sir Frederick Treves. Many of our readers will remember his record of impressions gathered in Eastern lands, and to those who have enjoyed them we may say at once that Sir Frederick Treves has greatly surpassed that achievement in the present admirable volume. Although his chapters are strung upon the itinerary of a prosaic "circular tour" of the Antilles and the Spanish Main, there is nothing whatever in them to suggest the globe-trotter's diary, but there is very much that bears witness to an eye of singular acuteness, backed by a living imagination and a ready wit; and there is no better proof of this than the poor impression which his photographic illustrations give by comparison with his text, although many of them are technically excellent. The book itself has a vividness that almost suggests a kinematographic record of faithfully coloured pictures, and as in such displays we are generally whirled from one set of events to another with startling suddenness, so does this writer make us change our outlook from a crowded modern quayside or the streets of a dreaming Spanish town to the quarterdeck of Drake's galleon, the assault on a treasure-stocked stronghold, or the blood-stained march of Morgan's desperadoes. Indeed, the traveller may well envy the author his faculty of peopling the places which he visits from out of the sleeping centuries; though they are scarcely ghosts which pass before us on his screen, but rather living, fighting, swearing men, cut-throats, heroes, and buccaneers, summoned up in the garb and fashion in which they lived their desperate lives. No less successful are his pictures of an antique polite and official world, the fine gentlemen of the colonies who, when buccaneer or chartered pirate was not engaged in sacking their towns, strutted their parts in the West Indian islands of the seventeenth century as bravely as any brother gallants on the Mall at home. We may instance the peep which he gives us at "St. Kitts in all its glory." But it is in the darker side of the picture that his descriptive force appears most strongly, a force that would seem at times almost too brutal were it not for the nearly unimaginable horrors upon which it is expended, the wiping out of Martinique by the death-cloud from St. Pierre, the destruction of Kingston, the ancient atrocities of the Gold Road in Panama, along which the buccaneers flogged their toiling slaves. This last chapter alone should earn the book a distinctive place in the English literature of travel, and very fascinating are those brighter pages in which the author tells of certain exploits of English ships and arms upon the Spanish Main, notably his magnificent story of "No Flint" Gray and "H.M.S. *Diamond Rock*." It is in reference to such heroic feats that he has named his book "The Cradle of the Deep," for, as he explains, "in the seclusion of those gorgeous islands, indeed, the long sea story of England was begun. The West Indies became the nursery of the British Navy, the school where the thews were hardened and the sea lessons learned."

But it must not be supposed that Sir Frederick Treves has no eye for the gracious side of his subject. We could quote many passages to show his appreciation of the wonderful beauty of the West Indies; such chapters as "The High Woods" of Trinidad breathe its very spirit and the allurements of many other islands receive their fair share of a praise which never gets out of hand, for although the author can people the places which he has seen with imaginations of the past he does not employ his fancy to embroider his descriptions of what he has seen, as over-enthusiastic travellers are prone to do. But when he is able to bestow complete admiration he can do so in such wise as in this description of his first sight of the humming-birds

which must commend itself irresistibly to all who have shared his joy of watching them in their native gardens:—

> They came from all sides, tiny winged wonders of blue, green, and gold, that for a moment one took to be great bees. They were so capricious, so alert, so quick as to be hard to follow. They sucked the honey from each flower while on the wing. They hung before the scarlet calyx in an ecstasy of worship, each little suppliant a whirl of green and gold. The vibrating wings could not be seen. There was merely a poised palpitating body with a dizzy halo on either side of it. It was not until they rested, with shut wings, on a spray near by, that they turned to birds again.

That is admirably seen and admirably written, and we could quote many equal passages.

We have little to find fault with in the book, except the statement on p. 12 that the English straw hat is the only head-covering required in any West Indian island. A prolonged stay in their lowlands would convert most people to the advantage of the sun-helmets which he scorns but which are worn frequently by the inhabitants. We also regret that the author's tour did not include a ride up the Blue Mountains of Jamaica. He would have found in them a worthy theme for the very able powers of description which he shows throughout "The Cradle of the Deep." We cannot finish our review of a book which we have enjoyed greatly without paying a tribute to the admirable humour of the chapter on "Saba the Astonishing," and we should much like to know if we may really believe it all, for it tells of an island that outdoes the conceptions of the most irresponsible comic opera.

A Text book of Surgical Anatomy. By WILLIAM FRANCIS CAMPBELL, M.D., Professor of Anatomy, Long Island College Hospital, Attending Surgeon to the Methodist Episcopal, Swedish, and Bushwick Hospitals; Consulting Surgeon to the Jamaica Hospital. With 319 original illustrations. London and Philadelphia: W. B. Saunders Company. 1908. Pp. 675. Price 21*s.* net.

THE scope of surgical anatomy varies greatly with the choice of the writer; with some it is merely that portion of anatomy a knowledge of which is especially needed by surgeons, but with others it includes not only this amount of anatomy but also some pathology, and occasionally even treatment. The value of these extensions of the original scope of works on surgical anatomy depends greatly on the author, and though Dr. Campbell appears to us to have included much that is not usually to be found in a book claiming to deal with surgical anatomy, yet he has written so well that we cannot complain. The book is excellent and there is little to which exception can be taken. The author appears to attach undue importance to the parathyroid glands and they hardly deserve the page that is devoted to them. We cannot agree with Dr. Campbell when he says that in transverse fractures of the patella, "all forms of treatment except open operation must result in fibrous union because of the fibrous curtain which has dropped between the fragments." We agree that the open operation is the best but subcutaneous wiring and even splinting methods may result in bony union. The book is well provided with illustrations.

Squint and Ocular Paralysis. By E. LUCAS HUGHES, M.R.C.S. Eng., L.R.C.P. Lond., Fellow of the Royal Institute of Public Health; Clinical Ophthalmic Assistant, Royal Infirmary, Liverpool. London: H. K. Lewis. 1907. Pp. 206. Price 6*s.* 6*d.* net.

SQUINT and disorders of mobility of the eye appear to exercise an extraordinary fascination upon students of ophthalmology, leading them to rush into print upon the slightest provocation or even without any encouragement at all. The present work is better than the majority, for it deals less with personal fads founded upon uncontrolled theorisation and gives credit to those to whom it is due, particularly to the real founders of the orthoptic method of treatment, Javal and Parinaud. This is doubtless due to the author's work as a clinical assistant in Paris, which has also led him to describe and to explain the uses of Rémy's diploscope, an instrument which is seldom referred to in English text-books. Mr. Hughes is, of course, an enthusiast; *cela va sans dire.* He is a whole-hearted disciple of the orthoptic school and we are not surprised to find that his enthusiasm outruns discretion. We do not agree with the statement that "with persevering orthoptic treatment, especially under the age of seven, strabismus, instead of rarely, may be said to commonly disappear of itself." We do not wish for a moment to undervalue this method of treatment in suitably selected cases, but we are convinced that it has been grossly overrated in the past and that its proper sphere of influence is likely to be obscured by the injudicious attitude which is so common in matters of this kind and is so much to be deprecated. The author has not neglected the work of English observers, notably Maddox and Worth; indeed, it appears to us that he has borrowed with much freedom from the writings of the latter author. The discussion of ocular paralyses follows the usual lines and contains nothing that will not be found in the ordinary text-books. The same may be said of the chapter on disturbances of muscle balance. We have already expressed the opinion that the book is better than most of the specimens of its class, and as such it can be confidently recommended to the student as a good introduction to this branch of ophthalmology.

LIBRARY TABLE.

Ueber Abdominale Totalexstirpation des Myomatösen Uterus. Von M. GRAEFE. Halle: Carl Marhold. 1907. Pp. 33. Price M.0·8.—In this paper Dr. Graefe discusses the question of total extirpation or removal by supravaginal amputation of the uterus containing fibroid tumours. Personally he favours the former operation and he brings forward the usual arguments in favour of his view. The matter is essentially one which each operator must settle for himself and which must, moreover, often depend on the exact conditions found at the time of the operation. Those surgeons who dread the subsequent occurrence of carcinoma of the stump of the cervix, and Dr. Graefe has himself collected 14 cases of this kind, will take care to remove the whole uterus. He does not believe that the objections hold good that total removal of the uterus leads to shortening of the vagina or endangers the functions of the pelvic floor, and he has not seen any such bad results follow this operation. At the same time it must be remembered that no operator has ever obtained such good results after total extirpation as those recorded by Zweifel—namely, 201 operations of supravaginal amputations with only one death. The author has performed total extirpation in 33 cases and he records the results of these operations as well as of 11 performed under similar conditions by his colleague, Dr. Wittauer, or a total of 44 cases with four deaths. Two of these he claims were not the result of the operation, giving a total mortality of 4·8 per cent. The question is one which time alone will settle and for our part the author does not convince us that the opinion that supravaginal amputation is preferable in the majority of such cases is a wrong one, nor do we imagine that he will succeed in converting to his view any other advocate of this eminently satisfactory operation.

Manual of Diseases of the Ear, Nose, and Throat. By JOHN JOHNSON KYLE, B.S., M.D., Professor of Clinical Otology, Rhinology, and Laryngology in the Medical College of Indiana, Department of Medicine at Purdue University; Otologist, Rhinologist, and Laryngologist to City Hospital, St. Vincent's Hospital and Dispensary, Indianapolis. Second edition, revised and enlarged. With 169 illustrations. London: Sidney Appleton. 1908. Pp. 627. Price 12*s.* 6*d.*

net.—The first hundred pages consist of a brief review of the embryology of the ear, nose, and throat, and the anatomy and physiology of the ear, the nose, nasal fossæ, accessory sinuses, and trachea, with the bacteriology and pathology of the ear, nose, and throat. The methods of examination, special instruments, and therapy, including a very large number of prescriptions, occupy the next 70 pages. Chapter IX. deals with diseases of the external ear and the next chapter is devoted to diseases of the middle ear, including injuries. We notice that Dr. Kyle has included in his work a short account of the work done by Escat and Alexander with regard to the effect of arteriosclerosis on the labyrinth; for treatment he recommends iodide of potassium The chapter on diseases of the nose is, like the preceding one, very full, especially considering the size of the book. Nasal polypi are, however, termed "myxomata." There is a very minute description of the submucous operation on the nasal septum which we think will be found very useful. Diseases of the oro-pharynx and pharynx, which are made to include diphtheria and diseases of the larynx, contain very good descriptions of all the various diseases. Although this work cannot be said to present very many subjects in a new light, still it is an extremely useful and valuable addition to books of a moderate size available for the use of practitioners of general medicine. It is extremely well written, the illustrations are very good, and it is a work which we believe will prove of great service to those who are too busy to have recourse to larger books.

JOURNALS AND MAGAZINES.

The Edinburgh Medical Journal.—In the May number Dr. James M. Beattie writes on acute rheumatism and details the evidence in favour of its bacterial origin. Under the title of "The Eclectic Treatment of Skin Diseases" Dr. W. Allan Jamieson reviews the work of Unna, now set out in detail in the monumental treatise of his pupil, Dr. Iwan Bloch. Professor Harvey Littlejohn and Dr. J. H. H. Pirie discuss micro-chemical tests for semen, the most hopeful being Barberio's picric acid reagent. Lieutenant-Colonel W. B. Bannerman, I.M.S., gives an account of recent researches into the causation of plague in India and concludes that infection is conveyed both from rat to rat and from rat to man solely by the agency of the rat flea.

The Scottish Medical and Surgical Journal.—In the May issue Dr. A. H. F. Barbour concludes his discussion of the evidence of frozen sections on the question of the lower uterine segment, and maintains that recent investigations do not tend to alter the accepted view. Miss Anne Mercer Watson writes on medical inspection of schools and criticises a recent memorandum from the Education Office with considerable severity. Dr. Stuart M'Donald reviews the position of pathology in the new curriculum of the University of Edinburgh and deplores its separation from practical medicine—a separation which has been effected at other seats of learning with very doubtful advantage. Some clinical notes by Dr. John Gordon deal with a case of vesicular eruption produced by a preparation called zambuk and with the alarming effects of a cantharides blister applied for sciatica; and Dr. J. Eason records some good results obtained in the eczema of infants and young children by thyroid substance.

The Medical Chronicle.—In an article on hydrocele in children Mr. E. D. Telford writes as follows: "A hydrocele if left to itself will eventually undergo an apparently complete cure;" while later he says that a certain "operation, if carried out in a series of hydroceles, will yield another argument for its adoption"—i.e., the credit for relieving a condition which would have disappeared spontaneously will be given to the operation and used as an argument for further proceedings of the same kind. We do not know if this is meant to be sarcastic or serious. Dr. Frank E. Tylecote narrates a case of post-typhoid furunculosis which yielded to vaccine treatment. An abstract of recent work by Professor von Noorden on nephritis is contributed by Dr. W. B. Warrington.

The Dublin Journal of Medical Science.—Dr. Walter G. Smith's contributions on chemical subjects are always interesting and the paper on clinical examination of the urine appearing in the May number of this journal is no exception to the rule. He constructs a urinary catechism, the questions in which may not seem any too simple even to those who are fairly familiar with the composition of the urine. "M.D. Theses," by Dr. Thomas O. Graham on epidemic diarrhœa and by Dr. T. J. Townsend Wilmot on syphilitic affections of the eye, appear in the same number.

THE GENERAL COUNCIL OF MEDICAL EDUCATION AND REGISTRATION.

THE session of the General Medical Council lasted until late on Wednesday afternoon, the unusual length of the sitting being due to the exhaustive hearing of the Catford case.

On Tuesday the following committees of the Council, in addition to those published in THE LANCET last week, were nominated:—

The Finance Committee, consisting of Mr. Tomes (chairman), Mr. Morris, Sir John Tuke, and Dr. Little.

The Dental Committee, consisting of the President, Mr. Morris, Mr. Tomes, Mr. Hodsdon, and Sir Thomas Myles.

The Dental Education and Examination Committee, consisting of Mr. Tomes, the President, Mr. Morris, Dr. Lindsay Steven, Dr. Finlay, Sir Thomas Myles, and Sir Charles Ball.

The Students' Registration Committee consisting of Sir Hugh Beevor, Dr. Norman Moore, Sir C. Nixon, Sir John Tuke, Dr. Adye-Curran, and Dr. Mackay.

We continue our report of the Catford case at the point at which we broke off last week.

MONDAY, JUNE 1ST.

The Catford Case.

Mr. HEMMING at the outset handed in an objection which the legal assessor perused.

Mr. LUSHINGTON: I can see that this is a protest against the attitude of the legal assessor and I do not think I ought to state it myself. I will hand it to the President.

The PRESIDENT said that this was not an objection but a protest. It was suggested that interruptions had been made with an object not favourable to the accused practitioner. The protest was not an objection and would be placed on record but it had no bearing on the future proceedings of the Council.

Dr. MCVAIL: You say it will be placed on record. Must that not be subject to the permission of the Council?

The PRESIDENT: We will consider that *in camerâ*.

Nurse PARKER, who is engaged at the London Hospital, was, by leave of the Council, then called as a witness. She spoke as to the attendance of Mr. Nicolas at a case at Thornton Heath on a date in April, 1907, on which one witness alleged he was in Catford.

Mr. HOWARD WALLACE, shipbroker, 85, Downhill-road, Catford, as a neighbour of Mr. Nicolas, stated that the latter did not take up his residence in Downhill-road until April 8th, 1907.

Mrs. ELLIS denied certain allegations made by a previous witness as to canvassing.

A succession of witnesses entered the witness-box. They were all acquainted with Mr. Nicolas. They denied that he had canvassed them and contradicted previous allegations.

Mrs. ROSE RIMMELL stated that she had formerly been a patient of Mr. Atkinson. She had taken in Mr. Nicolas as her doctor, because he had saved the life of herself and her little girl. She had not been canvassed by Mr. Nicolas but had called him in on her own accord.

Mrs. GALVIN, a widow, stated that she had taken a document round the neighbourhood and in one day had got it signed by 82 persons who were patients of Mr. Nicolas. By

signing the document those persons stated that they had not been canvassed nor had they heard Mr. Nicolas say anything disparaging of Mr. Atkinson.

Mr. HEMMING asked leave to hand in the document.

Mr. NEILSON asked how far documents of this sort were admissible in the Council's procedure. If the Council did not admit them in the ordinary form he would take objection to this document.

Mr. HEMMING pointed out that Mr. Nicolas was charged with systematic canvassing. By what method could Mr. Nicolas meet the charge? He could meet it by an *alibi*, or by a general denial supported in this way, or by his own denial. He produced the signatures of a large number of people who had signed the document that they had not been canvassed by Mr. Nicolas. If he could not meet the charge in that way how could he do it at all? There must be some way of holding a due inquiry. He could not subpœna these people. The Council had no power to issue a subpœna. He could not compel them to attend and give evidence.

Mr. LUSHINGTON said that the Council so far as possible regulated its procedure by that in a court of law. However, they were in this difficulty, because they had no power to compel the attendance of witnesses, or to put them on their oath, or to use ways by which courts of law could reinforce their methods of dealing with witnesses. In this case he was inclined to advise the Council to admit this document. He should point out to the Council what in his opinion it was worth. He added that the best evidence the Council could have was that of Mr. John Papa Nicolas to show whether there was anything in the case or not. In the meantime he would take in the document.

Mrs. GALVIN, cross-examined by Mr. Neilson, maintained that nobody asked her to take round the document; the idea of it came into her head by itself.

In answer to Mr. LUSHINGTON she stated that she had been supplied with no list of people. She went on her own accord to get up the signed petition. Mr. Hemming never came to her about it nor anyone from him.

Mr. HEMMING then went into the witness-box and stated that Mrs. Galvin came to him and said that she had heard Mr. Atkinson was proceeding against Mr. Nicolas. She suggested a petition. Mr. Hemming prepared it at her request and to that extent it was his document. He had prepared it just as if anyone had asked him to write a letter. He did not supply the list of names.

Mr. JOHN PAPA NICOLAS then proceeded with evidence in his own behalf. He handed in ten certificates testifying to character and professional ability.

Mr. HEMMING: Have you ever canvassed for patients?

Mr. NICOLAS: No.

Mr. HEMMING: Have you ever disparaged Mr. Atkinson?

Mr. NICOLAS: No.

Mr. HEMMING: Have you ever praised Mr. Atkinson up?

Mr. NICOLAS: Yes. Witness went on to state that he first had been assistant to Mr. Hugh Latimer Atkinson, the brother of Mr. Thomas William Atkinson. He was some time afterwards asked to go as assistant to the latter at Catford. After negotiation he went at a salary of £180 a year.

Mr. HEMMING: Was there anything said about signing a bond or agreement then?

Mr. NICOLAS: No. He went on to say that Mr. Atkinson attended the better class patients. He liked to pay the first visit to patients himself when possible.

Mr. HEMMING: When you had been with Mr. Atkinson for some time did you suggest leaving him?

Mr. NICOLAS: When I had been with him for about nine months I was one day at his surgery at his private house and when I was making up some medicine he asked what I was meaning to do as time was going on. I said I had really not made up my mind and I wanted to know something about an increase of salary or a partnership. He said that he was quite satisfied with me and he would think about the partnership himself, and he wanted me to stay two or three months at a salary of £200 a year. Then he said he would like to have a bond. I said, "No, I do not see the need for having a bond."

Mr. HEMMING: Who first mentioned the bond?

Mr. NICOLAS: Mr. Atkinson. He left Mr. Atkinson shortly afterwards to go abroad on private business.

Mr. HEMMING: At this time what was the relationship between you and Mr. Atkinson with reference to two points: firstly, a possible partnership; and secondly, the possible return to him at an increased salary as his assistant?

Mr. NICOLAS: He proposed to give me £200 a year if I stopped for three months or thereabouts and then a partnership. He parted with Mr. Atkinson on splendid terms.

Mr. HEMMING: When you left him what was the position?

Mr. NICOLAS: He agreed I was going back. Witness proceeded to say that on his return a communication was made to him through another doctor that Mr. Atkinson's attitude towards him had entirely changed and that conduct of the kind alleged in the charge was imputed to him. Witness was not conscious of having done anything to warrant this. He wrote to Mr. Atkinson and asked for an explanation. He did not get an answer but only a letter from the Medical Protection Society signed by Dr. Hugh Woods. Witness denied that he stated to Dr. Woods that he was not going back to Catford. He only visited him to try to obtain an explanation of the letter.

The witness had not completed his evidence when the Council adjourned.

The Council continued the consideration of the charge against Mr. John Papa Nicolas, and the examination of that gentleman was continued by Mr. Hemming, his solicitor.

Mr. NICOLAS went on to say that after he received the letter from Dr. Hugh Woods he was anxious to meet the complaint and to know who the complainant was.

Mr. HEMMING: Mr. Atkinson said that he did not ask for the bond before because he was foolish. Can you give any other reason?

Mr. NICOLAS: I cannot give any reason at all.

Mr. HEMMING asked him if all the time he was with Mr. Atkinson he had been loyal towards him and had done his best for his interests?

Mr. NICOLAS: I always did.

Mr. HEMMING: Did you work for him as hard as it was possible for any man to work?

Mr. NICOLAS: Yes. He denied that he had booked a midwifery case for himself after he returned. It was not true that he had told the person in question that he would give her his address when he returned to England. He did not give her a card with the slightest intention of taking her away from Mr. Atkinson.

Mr. HEMMING: Did you ever endeavour to injure Mr. Atkinson's reputation?

Mr. NICOLAS: No, it was the other way round.

Mr. HEMMING: In event of what you admitted taking place as to an assistantship or a partnership, would it have been to your interest to promote his ability and character rather than to disparage him?

Mr. NICOLAS: Yes.

Mr. HEMMING: Have you ever to any patient made a comparison between your own and Mr. Atkinson's methods?

Mr. NICOLAS: Never.

Mr. HEMMING: Have you ever made a comparison between your own and Mr. Atkinson's treatment?

Mr. NICOLAS: No.

Mr. HEMMING: Have you ever made disparaging remarks about Mr. Atkinson's medicine?

Mr. NICOLAS: No.

Mr. HEMMING: I believe you admit fully you have changed Mr. Atkinson's medicine.

Mr. NICOLAS: Yes.

Mr. HEMMING: Did you consult Mr. Atkinson when you changed the medicine?

Mr. NICOLAS: I always put it in the books whenever I changed my own or his. He went on to say that Mr. Atkinson gave him full permission to use his own skill when he went to patients.

When the proceedings were resumed after an adjournment for luncheon,

Mr. NICOLAS'S examination was continued. He went back to Catford in April, 1907, and started practice there because it was a growing place and there was room for doctors. He knew no reason why he should have refrained from going.

Mr. HEMMING: Since you have been at Catford I believe some patients of Mr. Atkinson have come to you.

Mr. NICOLAS: Yes.

Mr. HEMMING: What steps did you take with regard to Mr. Atkinson's patients?

Mr. NICOLAS: I would not accept any patients of Mr. Atkinson unless I was certain that patient had severed his connexion with Mr. Atkinson.

The witness was then cross-examined by Mr. Neilson, who took him step by step through his association with Mr. Atkinson. He went to Mr. Atkinson in the spring of 1906 and the question of signing a bond was not raised then. He denied that such a question was raised until a month

before he left. He repeated his assertion that when he left Mr. Atkinson there was an arrangement that after he returned from his voyage abroad he was to return to Mr. Atkinson first as assistant and then as partner.

Mr. NEILSON: Do you now tell the Council that there was no price fixed which you were to pay for the privilege of having a share in his practice?

Mr. NICOLAS: There was no money named.

Mr. NEILSON: You did not think you were going to get the share for nothing.

Mr. NICOLAS: Oh, no.

Mr. NEILSON: What was arranged?

Mr. NICOLAS: It was arranged I was to come back as assistant if I came back from abroad in about two or three months. He admitted no specific month was named. He thought that later on he was to get a share in the practice—he understood about a fifth. He was distinctly under that impression. The practice, he believed, brought about £1500 a year. That meant he would get £300 a year after three months. He thought that it was understood that the terms would be two years' purchase. Those were usual terms.

Mr. NEILSON: Was that ever named between Mr. Atkinson and yourself?

Mr. NICOLAS: It was understood.

Mr. NEILSON: You were wrong then in what you told the Council just now about the terms.

Mr. NICOLAS: I remember now what it was. He went on to say that he had read the declarations lodged in support of the case and he had seen many of the declarants with the exception of one, whose statement he characterised as an invention. When he knew what charges Mr. Atkinson was bringing against him he did not write to him. He could not write to a man who had insulted him. He went on to say that one of the witnesses who had appeared had said she had got 5*s*. to come to the Council.

Mr. NEILSON: Do you suggest that the London and Counties Protection Society had paid a woman 5*s*. to come and give false evidence?

Mr. NICOLAS: That was what she said.

Mr. NEILSON: Do you suggest, standing in the witness-box to give evidence before the Council, that this woman was paid 5*s*. to come here and give false evidence by the London and Counties Protection Society?

Mr. NICOLAS: Very likely she has from that society or some other society. Whether she gave true or false evidence I do not know.

Mr. LUSHINGTON: You suggest that the society has paid her to give false evidence.

Mr. NICOLAS: I cannot say positively the society. I withdraw, but she said she was paid 5*s*. He would not now suggest that the society had paid her to give false evidence. The cross-examination further dealt with certain detailed allegations.

Further hearing of evidence for the defence was postponed.

The Council adjourned.

WEDNESDAY, JUNE 3RD.

The Council resumed its sittings at its offices to-day, Dr. DONALD MACALISTER, the President, being in the chair.

The Catford Case.

The Council continued hearing evidence in defence of Mr. John Papa Nicolas, who had been summoned before it on a charge of having systematically canvassed in Catford for patients.

Mr. HEMMING (solicitor for Mr. Nicolas) said that it would be remembered that on Monday last he handed in a protest against the legal assessor. He had subsequently requested the legal assessor to refer the matter to his own Bar Council. He had had no reply.

The PRESIDENT: I cannot allow you to make that remark.

Mr. HEMMING: It is true.

Mr. HENRY G. FRASER, packing case maker, Sandhurst-road, Catford, was then called as a witness. He did not know Mr. Atkinson. Mr. Nicolas was his doctor. He had never been canvassed by Mr. Nicolas. He had recommended him on his own motion.

Mr. NEILSON: Do you know Dr. Atkinson?

Mr. FRASER: No, Sir.

Mr. NEILSON: What did you come all the way from Catford for?

Mr. FRASER: I came on Mr. Nicolas's behalf.

Mr. ARTHUR FRASER, also of Sandhurst-road, Catford, gave evidence that he had once consulted Mr. Atkinson, but he had gone to Mr. Nicolas. The reason of his change was that Mr. Nicolas was a clever man.

Mr. LUSHINGTON (the legal assessor): The Council has had a large class of this kind of evidence—namely, on the point that there are plenty of patients of Mr. Nicolas's who have not been canvassed. Of course I told you what we thought of that class of evidence before.

Mr. HEMMING said that he would call no more evidence. The legal assessor had said that he would advise the Council on certain points. Would that advice be given in the hearing of the accused?

Mr. LUSHINGTON said that it would not be so given. On the conclusion of the hearing the Council would begin to deliberate *in camerâ*. If the members of the Council called upon him to advise them *in camerâ* he was there for that purpose.

Mr. HEMMING: Will any statement be volunteered to the Council or will it only be in answer to any request? A judge only speaks to the jury in the presence of the accused. I protest against the legal assessor saying anything to the members of this Council unless my client hears it.

Mr. LUSHINGTON: I am not here to do as a judge, nor am I in attendance as a judge.

Mr. HEMMING: It will happen that there will be something secret after my client leaves this room. He then proceeded to address the Council and to review the case. He called attention to the high testimonials which had been given to the skill and ability of Mr. Nicolas, and the inquiry was the most serious one in which he could be involved unless it was an inquiry involving life and death. Mr. Atkinson admitted that at the time when Mr. Nicolas left his service he thought he was a young man of considerable ability. He afterwards turned round and attacked Mr. Nicolas, but there was nothing, he argued, to warrant Mr. Atkinson's attack on Mr. Nicolas. He had every confidence that he could demonstrate the character of Mr. Nicolas and his courage in meeting this charge, and also Mr. Atkinson's reluctance to come into the open and meet various charges fair and square. If the complaint against Mr. Nicolas was an absolutely honest one what objection could there be to letting him know what that complaint was? When the application was first made for the document there was not the slightest expectation that it would be withheld. The substance of his complaint was that he had been driven to take extreme steps in order to get a copy of the document to which he was entitled. It was not until there was a threat of proceedings against the Council that he succeeded in getting a copy of the document.

Dr. LITTLE (intervening) said he was very unwilling to rise, but he thought Mr. Hemming was not really aware of the case before the Council. They were not called on now to decide whether the modes of procedure of that court were right or wrong. They were called on to consider the conduct of Mr. Nicolas and the learned counsel had not said one word about that up to the present time. The members of the Council had no right to be kept there listening to arguments as to the mode of procedure of the court.

Sir CHRISTOPHER NIXON protested against the observations of Dr. Little. He thought he was justified in saying that after the large expenditure of time that had been given to this case there should be no attempt made by any member of the Council in any way to restrict the rights of the advocate for the accused practitioner.

Dr. SAUNDBY supported the protest of Dr. Little. Mr. Hemming had been impugning the procedure of the Council. If that procedure was wrong it could be dealt with at another time. No good could possibly come through going over matters which were perfectly well known to the Council.

Mr. HEMMING continued his address. He believed if the Council knew his object in making the observations he had done they would be a little more patient with him. He had no wish in any way to irritate members of the Council but rather to conciliate them. It was open to him to show that the procedure of the Council had very considerably impeded his defence in these proceedings. He expected that Mr. Atkinson would go into the witness box after he got a copy of the document but Mr. Atkinson had not gone into the box. It was the original wrongful withholding of the document and the absolute compulsion he was under to get it that had led to Mr. Atkinson being only partially cross-examined by him. Mr. Hemming then commented at length on Mr. Atkinson's declaration and pointed out a number of

variations between the original complaint of Dr. Woods and the charge as ultimately formulated by the solicitor to the Council. That fact alone, he submitted, justified him in strenuously asking for the original complaint. The charge his client had to meet had been enlarged and elaborated and now appeared dressed up in quite a different form. He contended that it was the original complaint his client should have to answer and that it did not lie with the solicitor to make a new charge. It was the solicitor's duty to frame the charge on the material originally placed before the Council and not to introduce anything fresh. He could show that there had been a very serious addition made to the original charge and to that extent he submitted the proceedings were irregular. His client was charged with "infamous conduct in a professional respect." The word "infamous" was one of the strongest they could find in the dictionary. At the very worst, what Mr. Nicolas had been guilty of was nothing more than a boyish indiscretion. If the word "infamous" was to be used in its ordinary sense it could not possibly be applied to such trivial acts as might have been committed by his client. Mr. Hemming went on to review the sworn declarations of the witnesses for the complainants and referred to the remarkable fact that no less than four of these declarations had been disowned by the people who signed them. He contended that the greater part of the evidence put forward by the London and Counties Medical Protection Society was utterly unreliable and ought to be received with contempt by the Council. His client's future was now, forsooth, to be dependent on the evidence in which there was clearly animus. He went on to deal with his cross-examination of Mr. Atkinson, taken in November.

Dr. SAUNDBY: If we are to listen to the reading of the evidence over again it would be taking up the time of the Council most unfairly.

Mr. HEMMING: I am only going to read the part relating to partnership. Mr. Atkinson, he said, admitted it might have been mooted but he had no recollection of it. He submitted that Mr. Atkinson's answers were vacillating on that point. It was inconceivable that Mr. Nicolas would go round and canvass Mr. Atkinson's patients if he was looking forward to be his partner or assistant. If there was a partnership or an assistantship mooted there could be no charge of canvassing before August, 1906. If Mr. Atkinson admitted mooting the question of partnership the charge failed. If Mr. Nicolas had any hope of being Mr. Atkinson's partner he would not have canvassed his patients. It would not have been worth his while. Mr. Nicolas was precise with regard to the mention of a partnership, and he would ask the Council to come to the conclusion that a partnership was mentioned. He contended that Mr. Nicolas in his cross-examination vindicated the consistency of his evidence. He said that Mr. Atkinson had not produced a patient which Mr. Nicolas had canvassed and taken away from him. Mr. Nicolas after he left Mr. Atkinson's employment went away from Catford for eight months. He set up about a third of a mile from a branch surgery of Mr. Atkinson in a district where there were hundreds of new houses springing up. When this charge was taken step by step its hollowness would be seen.

Mr. NEILSON then addressed the Council on behalf of the complainants. He pointed out that the case before the Council was entirely different from the action for libel in the High Court. This case was a charge against Mr. Nicolas for infamous conduct in a professional respect. Two different issues and entirely different matters were involved in the cases. The complaint against Mr. Nicolas was made by the Medical Protection Society as far back as June, 1907. The writ on which the action for libel by Mr. Nicolas was based was not issued until Nov. 15th. A comparison of these two dates exactly showed with what eagerness Mr. Nicolas pursued his redress in the first instance. Now as regarded the charge the burden of it was that Mr. Nicolas had systematically canvassed in Catford for patients by personal visits to patients of Mr. Thomas William Atkinson. It was suggested that that was not infamous conduct in respect of his profession. He would remind them of the definition of infamous conduct in a professional respect. Lord Esher in 1894 laid it down that if it was shown that a medical man in pursuit of his profession had done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute, then it was open for the General Medical Council to say that he had been guilty of infamous conduct in a professional respect. He submitted that definition for the consideration of the Council in all its aspects and he would say with the greatest confidence that if the charges which were alleged against Mr. Nicolas in this case and supported by evidence were true then no more complete example of infamous conduct in a professional respect could be found applicable to the medical profession, of which he was a member. If the Council found what he submitted was true he hoped that they would have no difficulty in finding the accused practitioner guilty of infamous conduct in a professional respect. He went on to review the incidents of the case. He asserted that when Mr. Nicolas was asked to sign the bond he refused and said he would rather go. He repudiated the idea that there was a suggestion for a partnership. The whole thing, he submitted, was an invention from start to finish. He suggested that if Mr. Nicolas asked Mr. Atkinson if there was a chance of partnership Mr. Atkinson replied not for several years. That was consistent with a statement made by Mr. Hemming. Why should Mr. Atkinson take this man who had given notice as a partner? Mr. Nicolas had no money. The whole position was entirely inconsistent in what Mr. Nicolas said now and what was said in November. He went on to say that when Mr. Nicolas was away from Catford from September, 1906, to April, 1907, there were rumours that he was coming back to practise in opposition to Mr. Atkinson. He would ask the Council to disbelieve some of the allegations made in regard to events about this time by Mr. Nicolas. It was Mr. Hemming's case that all these people who had been called for the complainants had conspired to raise a grossly dishonest case for the purposes of misleading the General Medical Council. It was that or nothing. He suggested that his (Mr. Neilson's) witnesses spoke the truth, that they came to tell the truth, and in their cross-examination their veracity was absolutely untouched. He submitted that Mr. Nicolas came back to Catford in pursuance of a scheme he had previously formed and in order to show Mr. Atkinson that he was going to do what he liked in the matter. The only explanation of the circumstances which was possible and true was that when Mr. Nicolas found that he did not get a bond, when he found he had not signed a bond, when he found it was necessary that he should sign a bond, he thereupon gave notice to go. He made the most of his time between the notice and the time he went. He had plans laid about a house before he went. He pursued these plans after he came back. He came back and canvassed the patients of Mr. Atkinson whom he could remember. Mr. Nicolas denied that. The question was, Which side should the Council believe? He submitted that his witnesses had spoken the truth and he asked the Council to find that Mr. Nicolas had canvassed the patients of Mr. Atkinson and that the Council should deal with him accordingly.

Mr. LUSHINGTON made a short statement in which he said that the Council had all along been guided by the advice of their legal advisers on points of procedure. He pointed out that one witness had made two declarations, one on one side, the other on the other. The solicitor and he had held it to be their duty that he should ask leave in such a case that they might look at both declarations to see whether they should advise the Council to send them to the Public Prosecutor.

This closed the hearing of the case.

After deliberation *in camerâ*,

The PRESIDENT said: Mr. John Papa Nicolas, I have to announce to you the decision of the Council. The Council have judged you to have been guilty of infamous conduct in a professional respect and have directed the Registrar to erase from the Register the name of John Papa Nicolas.

Mr. HEMMING asked that the erasure might be postponed for a month in order that he might apply for a writ of *certiorari*.

The PRESIDENT: You can make your application to the office in the usual way and we shall answer it.

The Public Health Committee.

On the motion of Dr. LINDSAY STEVEN the report of the Public Health Committee was received. It was in the following terms: An application has been received from the University of Sheffield for the recognition of its Diploma in Public Health. The committee has carefully considered these regulations and finds that they are drawn on similar lines to those of the Universities of Liverpool and Leeds. The committee observe, however, that the regulations as they stand are not as regards Rule 4 completely in accord

with those of the Council. Subject to modification in the above sense the committee recommend the Council to recognise for registration the Diploma in Public Health of the University of Sheffield.

Dr. LINDSAY STEVEN moved that the Council should recognise the Diploma in Public Health of the University of Sheffield conditional on the regulations being brought into accord with Rule 4 of the Council and that the President should be authorised to give effect to this resolution on being satisfied that the condition had been fulfilled. If the University of Sheffield would agree to make it clear that they demanded an examination and education in methods of hospital administration then he thought they might leave it in the hands of the President to grant the diploma full recognition.

Dr. NORMAN WALKER seconded.

The motion was agreed to.

The Reading of the Minutes.

Mr. MORRIS moved to discontinue the practice of having the minutes read over each morning by the Registrar immediately after the Council assembled. Nearly £1 was disbursed by the Council for each minute which it sat. The reading of the minutes on an average took a quarter of an hour. On working that out he found that it cost the Council from £11 10*s.* to £13 10*s* every time the minutes were read over to them. This session they had spent £108 for listening to the minutes being read. He thought that they should take the minutes as read, especially as they were circulated to members in printed form every morning.

Mr. TOMES seconded the motion.

Dr. MCVAIL suggested that the subject should be referred to the Executive Committee to consider.

After a short discussion a suggestion on the lines of that made by Dr. McVail was agreed to.

The Administration of Anæsthetics.

The Council then took up the consideration of the report by the Education Committee in regard to a communication from the Privy Council on the subject of the administration of anæsthetics. Its terms were: The following communication has been referred to the committee by the President:—

The Clerk of the Council, Privy Council Office,
No. 100,278. London, S.W., March 27th, 1908.

Sir,—Referring to a resolution (copy inclosed) adopted by the members of the Medico-Legal Society and others at a meeting held on the 24th instant, urging legislation with a view to making the administration of anæsthetics illegal except by duly registered medical practitioners, I am directed by the Lord President of the Council to state that his lordship will be glad to be favoured with any observations the General Medical Council may have to offer thereon.

I am Sir, your obedient servant,
The Registrar, General Medical Council. A. W. FITZROY.

[COPY.]

MEDICO-LEGAL SOCIETY.
MARCH 24TH, 1908.

At the close of the meeting Dr. Frederic Hewitt will propose, and Mr. R. Henslowe Wellington will second, the following motion:—

"That the two following resolutions be forwarded, in the name of the Medico-Legal Society, to the Privy Council and to the General Medical Council respectively:—

'That as the administration of any drug or drugs, with the object of producing generalised insensibility to pain or actual unconsciousness for any medical or surgical purpose, or during child-birth, cannot be safely undertaken without medical knowledge and skill, your petitioners humbly pray that legislation be granted whereby the administration of any drug or drugs with either of the aforesaid objects by any person other than a duly registered medical practitioner or someone acting immediately under his supervision, direction, and instruction, be made a penal offence.

That in view of the importance of the administration of anæsthetics, this society is of opinion that it is highly desirable in the public interest that every member of the medical profession, before he is registered, shall have received instruction in the administration of anæsthetics. It therefore earnestly begs the General Medical Council to consider whether they can see their way to include a course of instruction in anæsthetics amongst their "Requirements in regard to Professional Education."' STANLEY B. ATKINSON, } Hon. Secs."
DIGBY COTES-PREEDY, }

The committee recommend that the reply of the Council be in the following terms:—

I. The General Medical Council has consistently endeavoured to safeguard the interests of the public in matters relating to the practice of medicine. They will, therefore, willingly support any measure which has as its object to render illegal the practice, save by duly qualified and registered practitioners, of any department of medicine and surgery, including the branch of practice to which special reference is made in the communication from the Privy Council—viz., the administration of anæsthetics.

II. The Council has within the last year issued a "recommendation" to the Licensing Bodies that a course of study in the administration of anæsthetics should be included in the curriculum; and they have reason to believe that the "recommendation" has been already given effect to by many of the bodies.

Dr. MACKAY moved the adoption of the report and that the reply to the Privy Council should be in the terms which it recommended.

Dr. LINDSAY STEVEN seconded. He said that the subject the report referred to had been brought prominently before the body which he represented. In Glasgow the Procurator-Fiscal had been taking an active interest in the administration of chloroform, particularly in connexion with certain deaths. He had sent an inquiry to the Faculty of Physicians and Surgeons whether they could make any regulation whereby it could be insured that two medical men should be present where chloroform was being administered.

The motion was agreed to.

The Registrar, Mr. H. E. Allen, was reappointed, and on the motion of Dr. MACKAY a vote of thanks was awarded to the President for his service in the chair.

The session of the Council then came to an end and it adjourned until November.

It may be explained that owing to the length of the session and the very long time occupied in the consideration of the Catford case several items which were put down on the programme for discussion were postponed until the next session of the Council. The decision in the Catford case was not given till 6 30 P.M. and the discussion on the various motions was abbreviated so as to obviate a sitting on the following day.

ASYLUM REPORTS.

Kingseat Asylum, Aberdeen.—There were under treatment at this asylum during 1907 261 males and 237 females, being a total of 498 patients. The discharges during the year numbered 48. 16 men and 18 women were discharged recovered, the percentage of recoveries calculated on the admissions being 39·5. Of the recoveries 10 had been resident for at least three months, 11 between three and six months, seven between six and nine months, one between nine months and a year, four between one and two years, and one under three years. The deaths numbered 34—17 men and 17 women. These figures give a death-rate of 8·2 per cent. on the average number of patients resident and of 6·8 per cent. on the total number under treatment. We note that the medical superintendent, Dr. H. de M. Alexander, reports that the privilege of parole has been greatly extended and with the most happy results. Dr. Alexander writes: "It has been frequently observed that a few patients who are irritable, discontented, and lazy when confined become more contented and begin to work on their own initiative on being allowed greater liberty."

Glasgow Royal Asylum.—At this asylum the total number under care for 1907 was 563. The discharges during the year numbered 103. 27 men and 26 women left as recovered, a percentage of 36·5 on the total admissions. 30 recovered after less than three months' treatment, 18 after less than 12 months, and five after treatment lasting from one to four years. The deaths were 29 in number, giving a percentage of 6·8 on the average number resident. Dr. L. R. Oswald, the physician-superintendent, points with satisfaction to the fact that during the last three years 105 persons have sought treatment in his hospital of their own free will and argues therefrom that the public is slowly realising that the best hope for the mental sufferer lies in an early resort to such special treatment as can only be got in institutions properly equipped and adapted. Dr. Oswald further notes that the recovery-rate of voluntary patients is higher than that of those who are certified, that the duration of treatment is shorter, and that only in a small number of cases is it necessary to resort to certification.

Barnwood House.—The total number of certified patients under treatment during 1907 was 182. Ten patients were discharged recovered—that is, 29·4 per cent. on the admissions. The number of deaths was ten, giving a death-rate of 6·71 per cent. on the daily average number resident.

St. Andrew's Hospital, Northampton.—At this hospital the total number of patients under treatment during 1907 was 496. 34 patients were discharged recovered, being a percentage of 40·47 on the admissions. 13 deaths occurred, being a percentage on the average number resident of 3·17. The extensive alterations and additions which have been going on at this hospital are now completed. A resident medical officer has been appointed to look after the patients resident at the seaside home at Bryn-y-Neuadd.

THE LANCET.

LONDON: SATURDAY, JUNE 13, 1908.

The Medical Man and the Coroner.

IT may be remembered by our readers that in the years 1903 and 1904 the heading which we have printed above this article occurred very frequently in our columns, generally with the addition of the word "Pathologist." During those years we were engaged often in referring to the extraordinary position which was taken up by Mr. TROUTBECK, the coroner for Westminster and South-West London, in connexion with the giving of medical evidence in inquests which he held. Mr. TROUTBECK, it appeared, had assumed office on the understanding with the London County Council that he should adopt a policy recommended by the control committee of that body which obliged him to intrust the post-mortem examinations in all cases "of a special nature" to a specially skilled pathologist. So liberally did he interpret his mandate that—we quote from a letter by Mr. DONALD SHEARER in the *Times* of June 9th—"between May, 1903, and February, 1905, Mr. TROUTBECK found it necessary to call in a special pathologist, Dr. FREYBERGER, 816 times in place of the local or hospital medical attendant. During the same period the other seven coroners in London had between them 46 cases requiring special pathological knowledge. On most, if not all, of these 816 occasions public money was wasted; in not a few an erroneous verdict was arrived at for want of accurate clinical information." The justice of these remarks will be apparent to any fair-minded reader of many cases which we reported in 1903, cases in which the evidence of the medical practitioner who had attended the deceased would have had obvious value in correcting or corroborating post-mortem findings by clinical observations. In 1904 the legality of Mr. TROUTBECK'S conduct was challenged, and many instances of the omission of highly relevant evidence were reported to the LORD CHANCELLOR by a joint deputation of the British Medical Association and other societies which sought to call attention to the dangers of the new procedure. It will be remembered that Lord HALSBURY'S reply was a *non possumus*, for in a letter dated July 29th, 1904, the societies which had approached him were informed "though his lordship's present impression is not in favour of the coroner's practice, his lordship does not as yet see that there is such a case as would found the exercise of the only jurisdiction which he possesses—namely, to remove a coroner for misconduct in his office." The snub to Mr. TROUTBECK had, be believe, no effect on him.

We should hardly have present occasion to re-tell this story were it not that Mr. TROUTBECK has seen fit to give a further exhibition of his attitude towards the practice of medicine. It is true that in the former controversy he was wont to protest that he was guided by strictly impersonal motives, but his thinly veiled suggestions that professional opposition to his innovation was the simple result of fee-hunger and his free attribution of "impertinence" to medical men in disagreement with him caused doubts to arise as to his strictly judicial frame of mind. He may, of course, in his latest anti-medical dictum be again displaying strict impersonality, but his behaviour, while it can bring serious grief into suffering families, appears on the face of it to be instigated by a desire to show that the fee-hungry medical profession is also actuated by murderous instincts. The occasion for Mr. TROUTBECK'S activity against the medical profession arose as follows. It appeared by the proceedings at an inquest that Sir VICTOR HORSLEY had operated on a patient at the Bolingbroke Hospital, from whom he removed a cerebellar tumour. Three days after the operation the patient died, the cause of death, for which a certificate had been duly given to the registrar, being heart failure due to pressure which had been previously exerted on the nervous system by the tumour. An inquest was held by Mr. TROUTBECK, before whom, in the course of giving his evidence, Sir VICTOR HORSLEY protested against the holding of an inquest in so plain a case. The jury returned a verdict of "Accidental death," which the coroner suggested to them at the close of a homily which was virtually an attack upon the practice of surgery. Mr. TROUTBECK'S views on the progress of medicine ran something as follows. He said that operations were much more frequent than they used to be and that clearly they were to some extent the cause of the deaths that resulted; they could therefore not possibly be called natural deaths and came within the Coroners Act of 1887 which made inquests imperative in such cases; and he attempted, or is reported to have attempted, to clinch this argument by saying that such was the opinion of all coroners. It is hard to see how this statement can be reconciled with the following passage from the report of the Coroners Society for 1902–03: "In cases where a patient has recovered from the effects of the anæsthesia, and the death was due to a necessary operation or the disease for which the operation was performed, an inquest is not required; provided always that there is no allegation of neglect, serious rumours, or presumed want of skill on the part of the operator, or that the friends of the deceased do not request an inquest for their satisfaction." In this light any appeal by Mr. TROUTBECK to his colleagues must appear unfortunate; if he has quoted them as being of his opinion he is not a very accurate person. We can imagine a medical coroner, with some show of logicality, sitting to inquire into such an event as a death after a surgical operation, if scientific grounds appeared to warrant the inquiry, but how anyone of Mr. TROUTBECK'S attainments, which may be enormous in the legal direction, could possibly guide a body of men like a coroner's jury to any sort of verdict upon the circumstances of a surgical operation passes imagination.

Mr. TROUTBECK'S departure shows him once again to be ignorant of the spirit of the medical profession. Is he correct in his legal interpretation of his duties? The third section of the Coroners Act of 1887 provides that where a coroner is informed that the dead body of a person is lying within his jurisdiction, and that there is reasonable cause to suspect that such person has died a violent and unnatural

death or has died a sudden death, of which the cause is unknown, or "in such place or under such circumstances as to require an inquest in pursuance of any Act," the coroner shall summon a jury. He would be a zealot, indeed, who construed this language to mean that an inquest must be held in every case where a patient has not proved amenable to surgical treatment. If Mr. TROUTBECK bases his contention on the fact that death in such a case is "unnatural" he would have to go further and say that the cause of every death taking place after medical treatment of any kind should be investigated by a coroners' jury. It is further implied in the Registration Act of 1874 that a death from disease under treatment *secundum artem* is not unnatural, and without such a safeguard medical practice would be impossible. The more we reflect upon Mr. TROUTBECK'S latest move the more he seems to have been instigated by a simple desire to wound the medical profession which cannot be got to regard him as anything but mischievous. But the public will suffer if Mr. TROUTBECK has his way even more than the medical profession. Mr. TROUTBECK will not be able to persuade juries that medical men operate for the love of giving pain and from lust of gold, regardless of the true needs of the patients; and the distress caused by the publicity of unnecessary inquests to many families in the first grief of a bereavement will be extreme.

The Value of the Surrey Isolation Hospitals.

DR. EDWARD C. SEATON, the county medical officer of health of Surrey, has recently issued an interesting and instructive report with reference to the effect of the operation of isolation hospitals and compulsory notification in that county upon the behaviour of scarlet fever, and in his investigations he has been ably seconded by Dr. JOHN WILLIAMSON who has conducted some original and valuable researches upon the subject. As a frontispiece to the report is a chart showing the death-rate from scarlet fever per 1,000,000 of the population in England and Wales from 1856–1906, and this chart brings out the now well-known fact that a marked decline in the death-rate of the disease had commenced prior to the general provision of isolation hospitals and long antecedent to the introduction of compulsory notification. This circumstance is obviously one of first-rate importance in a consideration of the influence of isolation but it is nevertheless easily possible to overestimate its value. Question at once arises as to what this decline in the death-rate really means. Does it imply diminished prevalence of the disease, or may it be that while the disease itself is becoming far less virulent its actual prevalence is as great as, or even greater than, before? This question is very difficult, if not impossible, to answer, inasmuch as antecedent to notification we had practically no data as to prevalence, and even with notification we must be careful in generalising. Increase or decrease in the number of notifications may really mean nothing more than a sort of systole and diastole of the type of the disease—at one period easily recognisable, at another only so with difficulty. Again, our medical practitioners may be becoming more expert in the recognition of the disease than formerly.

It must, nevertheless, be said that the evidence in favour of a diminished fatality-rate of the disease during recent times is very strong—indeed, practically conclusive, and the question to be asked is, How far is such decrease to be attributed to the operation of notification and isolation? Before an answer could be found to this question it would be desirable to investigate the behaviour of scarlet fever in countries where there are practically no isolation hospitals, but as Dr. SEATON has not gone into this aspect of the question we shall not do so ourselves; and it has certainly to be admitted that in the present unsatisfactory condition of statistical returns in almost every other country but our own journeys into international figures are perilous undertakings likely to lead to inferences of a far-reaching but not improbably mischievous and misleading character. In so far as Surrey is concerned, Dr. SEATON concludes that isolation and notification have had an influence in the reduction both of the death-rate and the fatality-rate of scarlet fever, but he does not find it possible to detect how far, if at all, the attack-rate has been influenced—i.e., it cannot be shown, he thinks, that the preventive measures taken have materially affected the notification case-rate. He finds, in fact, that there is "no very obvious correspondence between the hospital isolation and the prevalence of the disease." The fact that there is "somewhat less scarlet fever in a district with isolation accommodation than in the same district without" is, of course, as Dr. SEATON recognises, not very convincing as to the value of isolation hospitals, and it is at this stage that Dr. WILLIAMSON'S investigations may be usefully introduced.

He has at considerable pains investigated the history of all notified cases in the Epsom and Dorking combined districts from 1891–1905 and his results are presented in the form of charts, "hospital" and "home" treated cases being depicted separately and, by way of eliminating the possibly disturbing factors of good class houses, he has dealt with cottage cases only—i.e., cases where the opportunities for proper isolation were clearly remote. The general conclusions brought out by these charts are those which we have on many occasions predicted in these columns—i.e., that the major damage as regards the infection of other persons is brought about before the first case has been recognised, notified, or sent to hospital, and that consequently the influence of isolation hospitals is less than had at one time been anticipated. Dr. WILLIAMSON'S "hospital" charts indicate that a very high percentage of secondary cases were infected before the removal of the first patient; they show, indeed, that somewhere about two-thirds of the secondary cases are thus to be accounted for. The charts, however, bring out the instructive and consoling fact that the advantage as regards the avoidance of secondary cases is always on the side of the hospital until after the seventh week from the occurrence of the primary attack when the so-called "return" cases begin to appear and, seemingly, influence the "hospital" chart to a materially greater degree than the "home" chart. As Dr. WILLIAMSON concludes, "it is plain, therefore, from the above charts and figures that an earlier discovery or recognition of cases is necessary to make hospital isolation fairly effective."

There is no doubt, as we have for years past urged, that it is the *unrecognised* case which governs the situation both as

regards scarlet fever and many other diseases, and the work before us is not that of sitting with arms folded but of endeavouring to discover the unrecognised case. There can, we think, be no serious question in the minds of the vast majority of medical officers of health alive to their responsibilities that properly administered isolation hospitals have a very distinct value in our administrative machinery and that the public will continue to demand their provision. It is for this reason that we regret to see certain medical officers of health rather discouraging the erection of such hospitals since there are so many local authorities who are only too anxious to catch at any straw with the view of justifying their inaction. Numerous instances of this have come beneath our notice. It would be especially regrettable at the present time, when the medical inspection of school children is actually in the making, were we to discourage the erection of isolation hospitals. The steady progress of this inspection movement cannot fail to bring to notice very many unrecognised cases of infectious disease which hitherto have escaped notice, and the interest which the teachers will gradually acquire in this inspection will prove eventually to be a powerful factor in the earlier recognition of communicable diseases. Much of the future attitude of local authorities with reference to the provision or non-provision of isolation hospitals depends, we imagine, materially upon that of Dr. ARTHUR NEWSHOLME, the recently appointed medical officer of the Local Government Board, and having regard to the growing scepticism of local authorities as to the value of isolation hospitals, it might serve to steady public opinion were some official pronouncement from Whitehall to be forthcoming.

Tics and their Treatment.

THE term "tic" has long been employed to denote certain habitual and meaningless gestures. Great confusion has, however, existed in regard to the group of conditions to which it has been applied. Even the etymology of the word is somewhat obscure and it has been suggested that it was originally onomatopœic and that it conveyed the idea of repetition. It has long been employed in France and so long ago as 1665 JEAN JOURDIN described the *tique* of horses. It is to the French physicians that we are especially indebted for the definite separation of the true tics from conditions which resemble them, notably to TROUSSEAU, whose description is characteristically clear and accurate, and to CHARCOT, who first established the significance of the psychical factor in tic. GILLES DE LA TOURETTE advanced our knowledge by separating the form to which his name is usually attached, while BRISSAUD and his pupils have further studied the conditions and devised special methods of treatment. Recently M. HENRY MEIGE and M. E. FEINDEL have published a monograph on the Tics, which has been translated into English by Dr. S. A. K. WILSON.[1] This book is a most suggestive contribution to the study of the disease and is well worthy of our readers' consideration. After a detailed analysis of the clinical features of the various tics the authors define the condition as follows: "A tic is a coördinated purposive act, provoked in the first instance by some external cause or by an idea; repetition leads to its becoming habitual and finally to its involuntary reproduction without cause and for no purpose, at the same time as its form, intensity, and frequency are exaggerated; it thus assumes the characters of a convulsive movement, inopportune and excessive; its execution is often preceded by an irresistible impulse, its suppression associated with malaise. The effect of distraction or of volitional effort is to diminish its activity; in sleep it disappears. It occurs in predisposed individuals who usually show other indications of mental instability." Tic is thus to be regarded as a psycho-motor affection, and in tracing its evolution the authors show that the cortex is involved. The original movement may have been voluntarily executed in response to some irritation but in the subject with a tendency to tic the movement is repeated even after the source of irritation has ceased and soon the reiterated gesture becomes habitual and automatic. An interesting chapter deals with the mental state of the subjects of tic. Although they may be, and often are, of high intelligence and fertile in imagination, they usually present on careful investigation definite evidence of mental instability. The most constant feature appears to be one of "mental infantilism"—evidenced chiefly by retarded or arrested development of the will, so that the *tiqueur* cannot exert his will sufficiently to check his tic permanently. The *tiqueur* is also often irresolute, lacking in perseverance, and is subject to vagary and caprice. Tics are also not infrequently associated with obsessions and with various phobias, such as agoraphobia and claustrophobia, indeed some obsessions occurring in the subjects of the tic have been described as "psychical tics" or "tics of idea," terms which M. MEIGE and M. FEINDEL most strongly deprecate the use of, since they insist on the dual nature of tic, one element being mental, the other motor, and the two being inseparable, in other words, they maintain that a mental condition which does not eventuate in some motor reaction is not a tic. In regard to the etiology of tics, heredity is shown to be of great influence, though in regard to direct heredity the factor of imitation is difficult to separate, but dissimilar heredity, both neuropathic and psychopathic, is also very frequent. The environment is a matter of great importance, especially where children are concerned, the parents of *tiqueurs* being often inclined to over-indulge and to "spoil" them. The pathological anatomy of tic is still to seek; hitherto no lesion has been discovered in such cases to which the symptoms can be referred and although cases are on record in which lesions have been described M. MEIGE and M. FEINDEL are of opinion that in all of them the diagnosis has probably been an erroneous one, conditions of spasm from irritation being regarded as tic.

The study of the motor reaction of tics shows that they may be clonic or tonic in character. The various tics are described by M. MEIGE and M. FEINDEL according to the regions which they affect—viz., facial tics, auditory tics, tics of the eyes, including nictitation and vision tics; sniffing tics, sucking tics, tics of the chin, of the tongue, sometimes called licking tics; tics of the jaws, biting and masticatory; tics of the neck, of the

[1] "Tics and their Treatment," by Henry Meige and E. Feindel With a preface by Professor Brissaud. Translated and edited with a critical appendix by S. A. K. Wilson, M.A., M B, B.Sc.Edin. London: Sidney Appleton. 1907. Pp. 386. Price 9s. net.

trunk, of the arm and shoulder; and tics of the lower extremities, including walking and leaping tics. As examples of tonic tics mental trismus and mental torticollis are instanced. Under the heading of tics of speech, echolalia and coprolalia are described, since they are not infrequently to be observed in the subjects of tic, although the authors do not regard them as tics but simply as associated defects. Gilles de la Tourette's disease is described as a separate form in which the course is regularly progressive and one which is often associated with echolalia and coprolalia. Another form is described as the variable chorea of Brissaud. A chapter is devoted to the antagonistic gestures and stratagems to which the subjects of tic resort in misdirected ingenious attempts to overcome their special tics. In regard to diagnosis, the distinction of tics from stereotyped acts, from spasms, from chorea, myoclonus, athetosis, tremors, and professional cramps is discussed in detail. It is especially in regard to spasms, such as facial spasm and spasmodic torticollis, that difficulty may occur, and illustrative cases are given to show the methods to be adopted. In regard to prognosis, we are told that this depends solely on the mental state of the patient. "He who can will can effect a cure," say the authors, but they also admit that the tendency to tic remains and that whereas tics of childhood are curable a permanent cure is less frequent in the tics of adult life. The treatment of these conditions is given in considerable detail and comprises, in addition to medicinal and certain physical forms of treatment, such as massage and electrical methods, the re-education system introduced by Professor BRISSAUD, which is briefly epitomised by the authors as "a combination of immobilisation of movements with movements of immobilisation." The patient is directed to perform certain appropriate exercises, some being directed towards teaching him how to preserve immobility, while the object of others is to replace an incorrect movement by a normal one. The exercises have in general to be performed in front of a mirror. Examples are given in illustration of the methods of treating various special tics. The book is a model of what a monograph on a special subject should be, for it is clearly and critically written and it is suggestive in character as well as instructive. Dr. WILSON is to be congratulated on the excellence of his translation and on rendering so useful a work available in English form.

At a recent meeting of the Neurological Section of the Royal Society of Medicine[2] a discussion on "Tics" was opened by Dr. HENRY HEAD who paid a well-deserved tribute to the part played by French observers in developing our knowledge of this subject. He also laid stress upon the mental factor in the development of tics and stated that although the *tiqueurs* may be above the average in ability there is always something that betrays their want of balance. Dr. E. FARQUHAR BUZZARD pointed out an exception to the general rule that a tic originates in a voluntary movement in that form which occasionally results after a severe attack of chorea. Dr. L. G. GUTHRIE emphasised the importance of distinguishing between tics and spasms, the latter being merely motor reactions to local irritation somewhere in a spinal or bulbo-spinal arc, whereas the tic is a psycho-motor reaction. He also deprecated the use of the term "habit spasm" as a synonym for the tics, since they are certainly not spasms nor are they true habits. The subject is one which is deserving of notice, since the condition is frequently regarded as irremediable, whereas by careful treatment marked amelioration and in some cases actual cure can be effected.

[2] Proceedings of the Royal Society of Medicine, Neurological Section, Jan. 30th, 1908, p. 41.

Annotations.

"Ne quid nimis."

THE DANGERS OF MOTOR OMNIBUSES.

THE recent attack made upon several motor omnibuses in Mile End-road after one of their number had run over a child showed that a very strong popular feeling exists against these vehicles, caused by the reckless way in which too often they are driven. As they are maintained largely for the purpose of what may be called "popular" traffic this feeling is worthy of note. The Stepney borough council has, we observe, been considering a resolution to be laid before the Home Secretary and the Commissioner of Police in favour of reducing the maximum speed of all motor and other vehicles within the County of London to ten miles an hour. This would be a regulation which would render London streets safer and less noisy, but if it were to be applied universally it would be extremely difficult to enforce owing to the number of private carriages the owners of which would be found to infringe it, particularly in quiet streets. Motor omnibuses, as a general rule, are driven with far more care and skill than was the case when they were first introduced. We cannot, however, judge them as a whole from what we see of their movements in the West-end and by day. It is at night, and particularly in places where a public frequents the streets whose protests are not likely to reach the ears of those in authority, that they will be found to exceed the proposed limit of ten miles per hour considerably and to take risks which they ought to avoid. The police in regulating them in this respect might also note the manner in which they are allowed to be overcrowded in the evenings when their passengers are going home from their day's work. These, no doubt, prefer to travel rapidly, but that is no reason why people who have secured seats in a motor omnibus should have their safety endangered and their scanty supply of air obstructed by "strap-hangers," while horsed omnibuses proceed in the same direction half empty. We note that the committee of the Stepney borough council responsible for the recommendation to restrict speed had before them figures showing that in 1907 there were 16,010 accidents caused by horseless vehicles on the roads, of which 4723 were due to motor omnibuses. Whether these figures are those of London only or of a wider area we are not aware, but the question in any case is of some gravity.

AN EARLY TEMPERANCE TRACT.

IT is open to the social historian to speculate how far the so-called "crying evils" of the day are an affair of journalistic and literary tradition rather than of actual induction from statistics. It is assumed by many excellent people that England is rapidly degenerating owing to habits of intemperance, to the growth of gambling and immorality, to the love of pleasure, and to the pursuit of gain, but these censors of their time are not students of history and the evolution of manners. Rather they are highly suggestionised readers of cheap newspapers and followers of particular prophets whose tradition in both cases may be said to date back to the palmy days of

Puritanism. As long ago as 1628 William Prynne published the first rabid temperance tract under the title, "Healthes Sicknesse, or a Compendious and briefe Discourse, proving the Drinking, and Pledging of Healthes, to be Sinfull, and utterly Unlawfull unto Christians; by Arguments, Scriptures, Fathers, Moderne Divines, Christian Authors, Historians, Councels; Imperiall Lawes and Constitutions; and by the voice and verdict of prophane and Heathen Writers." It is a question whether Prynne did not set going for all time the bogey of national intemperance. He seems to have been among the first to discover that drunkenness was *par excellence* the national vice, but he believed this failing to be of recent introduction into England. According to him the custom of drinking healths came into England from Europe—from Germany, Poland, and Scandinavia. He condemned the custom as a relic of primitive devil-worship and rightly maintained that, owing to the principle of "no heel-taps," it involved an excess of drinking which was injurious to health. He fails to recognise that Anglo-Saxons have always been robust drinkers and he attributes all the intemperance of his age—which was very nearly the period of Falstaff—to the habit of "healthing." His learning is so vast and his citations from the Greek and Roman writers are so copious that we are inclined to believe him to have been rather a student of books than an observer of facts. The England of 1628 drank wine and ale, and strong waters were only introduced into common use by his own kindred, the "saints" of the time of the Civil War. It was not till quite a century after Prynne's time that gin began to be the ruin of the eighteenth century working-classes. When Prynne penned his terrific tract England was probably neither more drunken nor less sober than at any period since the days of Hengist and Horsa.

MILK EPIDEMIC IN CHRISTIANIA.

Dr. Sömme of Mesnalien Sanatorium, in the *Norsk Magazin for Laegevidenskab* describes an extraordinary milk epidemic in Christiania which broke out during the first fortnight in March. The attack in almost every case began with a sore-throat. It was speedily traced to the milk-supply of one dairy and thence to a cow with a diseased udder. The cow was slaughtered and a bacteriological examination of the abscess found in the udder led to the isolation of streptococci in every way identical with the streptococci obtained from patients suffering from the epidemic. The streptococci showed the following characteristics: moderately long chains, each link being fairly long and divided longitudinally. They stained with Gram's method. Stained specimens suggested the presence of a capsule. On a serum culture the growth showed a thin moist film, almost watery, only a little adhering to a thread drawn over it. It did not grow on ordinary agar—on agar made alkaline the growth was slight. Ready growth took place in ordinary bouillon, ascitic and serum bouillon, and on plates of serum bouillon (Löffler's) with dextrose or lævulose added. Mice died in from 12 to 24 hours after intraperitoneal injections of minute quantities of the culture and cultures were easily obtained from the blood. It was found to be much less virulent for rabbits. The number of cases of the epidemic notified was 548, but as notification was voluntary it is probable that the number was considerably higher. An interesting feature of the epidemic has been the high proportion of adults affected, the ratio of adults to children being about 3 to 1. The clinical picture of the illness was as follows. High temperature, 40° C. or more, with sore-throat. The surface of the tonsils, pharynx, and downwards towards the larynx was of a glistening red; in other cases the redness was confined to punctate areas, and in yet others there was a diphtheria-like membrane which was easily removed. In the majority of cases the appearance of the throat was scarlatinal rather than diphtheritic. Swelling of the glands extended from the angle of the jaw downwards along the sterno-mastoid to the clavicle. In some cases the swelling was slight but the glands were excessively painful on pressure, and this condition sometimes lasted for a long time. Often the temperature fell by crisis after three days, then a relapse would occur followed by another crisis, febrile and non-febrile phases alternating during a period of many weeks. Complications, chiefly of a pyæmic character, were numerous; thus angina phlegmonosa occurred frequently; in one case a number of abscesses occurred on both sides of the throat accompanied by copious hæmorrhages from the nose and mouth. The odour of the pus was very offensive. One patient was almost choked by a purulent uvula of the size of a man's thumb. Further complications were rhino-pharyngitis, laryngitis, otitis media, ulcers of the tonsils and palate, empyema of the antrum of Highmore, infection of the accessory cavities of the nose, glossitis of such virulence that the swollen organ protruded from the mouth, erysipelas, in one case dacyro-cystitis, stomatitis, œsophagitis with dysphagia, and albuminuria. Other complications were pyarthrosis, acute rheumatic fever, synovitis, bronchitis, empyema, pleurisy, pericarditis, hæmorrhagic nephritis, phlegmasia alba dolens cruris, paresis of the left hamstring muscles, and erythema of both legs two weeks after infection. Gastro-enteritis and diarrhœa were apparently not common. Of the cases ending fatally the following may be cited. Case 1. A male, aged 31 years; heart failure occurred on the fifth day. Case 2. A female, aged 74 years; fever, vomiting, pain, and effusion in the left knee-joint and right carpus. Death took place a fortnight after infection. Characteristic streptococci were found in pus from the knee-joint. There were parenchymatous degeneration of the liver and kidneys and fatty infiltration and dilatation of the heart. Case 3. A male child, aged 16 months; diarrhœa, vomiting, fever lasting only from four to five days, and empyema. Death ensued on the eleventh day. Case 4. A female, aged 47 years; general glandular swelling. The patient was convalescent after the third week, then ensued sudden onset of pain in the muscles, principally those of the lower extremities, and pain in both knees and wrists, also in the temporo-maxillary joint; the temperature gradually rose to 43° C., accompanied by dyspnœa and œdema of the lungs. Death occurred a week after the onset of the relapse. Post mortem there were ecchymoses on the surface of the heart but none on the lungs. The spleen was soft and swollen, with well-defined markings. Serous exudate was present in the knee-joints. Case 5. A female child, aged four months (case of fatal secondary infection). An inflamed nævus had been treated with lanolin also used for an otitis media in an older child suffering from the milk epidemic. There was meningitis and lumbar puncture showed the typical streptococci. The child was breast-fed. A somewhat similar epidemic involving 15 patients is described by Dr. C. Grey-Edwards and Mr. W. D. Severn in THE LANCET of June 12th, 1897, p. 1605.

"CANARY FEVER."

IN a recent number of the *Annals of Tropical Medicine and Parasitology* Dr. C. E. Walker contributes an interesting study of a troublesome illness to which visitors to the Canary Islands are particularly susceptible and which is generally known as "Canary fever." The result of Dr. Walker's inquiry has been to show that this is simply due to a bacterial infection of food, such as might occur in any country, and he has been unable to find any evidence as to a specific infective agent in the disease. The symptoms are those of a gastro-enteritis with very severe griping pains, and sometimes the passage of blood-stained mucus from the bowel, and from 60 to 80 per cent. of the visitors to the

island are said to suffer from it. A curious feature about its distribution is that it is almost entirely confined to visitors to the hotels, the dwellers in private houses being as a rule free from the disease. This and other reasons have led Dr. Walker to acquit the milk- and water-supply from the responsibility of causing it, and he has been led to believe that it is due to a bacterial contamination of food, and especially of the meat, by flies, for the precautions taken to keep them out of the larders are very imperfect in the hotels, where also frozen meat is consumed that has been subject to fly contamination in transit. The dwellers in private houses, on the other hand, eat fresh meat almost exclusively and are very careful to keep it free from flies. Dr. Walker has also noticed that people who have partaken of soups and *réchauffés* that have been prepared without bringing them to the boiling-point, as is frequently the case in hotels, often suffer from the symptoms which he ascribes to fly infection of the cold meat from which such dishes are prepared. He concludes his paper with a set of useful suggestions for the preservation of all food from the risk of such contamination and lays stress on the necessity of sterilising by steam all dishes and cooking utensils. It will certainly be worth the while of the hotel keepers of Las Palmas and the neighbouring islands to put their houses in order in this respect, and should the fly theory of the disease be confirmed it is not too much to expect that the local authorities will protect their European visitors by regulations as to the storage and preparation of their food, for the continuance of such a troublesome "epidemic" must seriously jeopardise the popularity of the islands as resorts for the winter, at which season the disease is most prevalent.

PARALYSIS OF THE SUPERIOR OBLIQUE MUSCLE OF THE EYE AS A RESULT OF DIRECT INJURY.

PARALYSIS of the external ocular muscles as a consequence of direct traumatism to the eyeball and orbit is not of very frequent occurrence. Dr. Michael Kos of Przemysl, in a paper published in the *Wiener Medizinische Wochenschrift* of March 14th, states that up to the year 1906 38 cases had been collected from the literature by various observers, and that among them there were only two cases of paralysis of the superior oblique muscle. He records in detail an interesting case observed by himself as a further example. The patient was an artilleryman who sustained a direct injury just above the inner canthus of the right eye owing to losing his balance while mounting a provision wagon and falling in such a way as to cause a projecting piece of iron of the size of the little finger on one of the cross bars of the wagon to penetrate the orbit in the situation already mentioned. Not only were the soft parts lacerated but in addition the orbital plate of the ethmoid bone was fractured, so that on sniffing, air escaped from the wound for two days after the injury. There was considerable swelling of the contused tissues in the wound but healing occurred in nine days. After the bandages were removed the patient found that he was unable to walk properly owing to diplopia. He was therefore admitted into hospital. The site of the injury was indicated by a discoloured area of skin over a swelling of about the size of a pea in the nasal part of the upper lid on the right side. No alteration was observed about the globe of the eye and the fundus was found to be normal. Vision proved to be 6/6. Diplopia was present which the patient endeavoured to overcome by holding his head in a peculiar manner in order to avoid the giddiness which otherwise resulted. The diplopia was confined to the lower half of the field of vision. In the median line the image from the right eye was situated on the right, somewhat lower than the image from the left eye, with the upper end inclined inwards, but the separation of the images was so slight that the upper end of the right image touched the left. On looking downwards and to the left the deviation was at its maximum but the images were parallel. In order to avoid the diplopia the patient adopted the following position. His head was inclined towards the left, somewhat bent forwards, and rotated towards the right. It was evident that the superior oblique muscle was paralysed. There was no indication of any injury to its attachment to the eyeball or to the belly of the muscle itself, although the latter could not be definitely excluded. Dr. Kos suggests that the most probable explanation is that the trochlea itself was lacerated or detached by the fracture. In regard to treatment the faradic current was applied for some weeks without any improvement resulting. No operative surgical treatment was undertaken.

THE EQUINE STEAK.

RIGHTLY or wrongly, sentiment, at any rate in this country, is very vigorously directed against the use of horseflesh for food. The feeling is very strong and not a few persons evince disgust at the mere mention of the suggestion that an equine steak can rival the usual beefsteak as regards flavour and tenderness. But there are connoisseurs who allege that a Chateaubriand steak is all the better from the gustatory point of view when it is prepared from the flesh of the horse. The prejudice against horseflesh has doubtless arisen from a familiarity with the hard-working habits of the animal, and partly perhaps on account of its association with the diet of the cat. There is some idea that hard work renders the fleshy parts of the animal unfit for food and yet in countries where it has been the custom to eat horseflesh the demand is rapidly growing. In Paris, for example, it is reported that last year close upon 50,000 horses were killed for food, this showing an increase of 5000 horses on the figures of the previous year. It would appear, however, that the consumers of horseflesh are to be found chiefly amongst the poor people who are not able to pay the higher prices for beef or mutton. Still, the fact remains that horseflesh is a nutritious meat and it can be prepared in such a way as to be an attractive meat food which need not be tough or objectionable from the point of view of flavour. There are no physiological reasons against the use of it, and indeed the immunity which the horse (unlike the ox) enjoys from tuberculous disease is a decided point in favour of the use of horseflesh as against beef. Prejudice, however, dies hard, and not, perhaps, until the motor has completely driven the horse from a life of toil will its flesh be added to our list of meat foods to relieve the present monotonous round of mutton and beef. Whatever may be said in favour of the value of horseflesh for food, and whether sentiment is right or wrong, there can never be any justification for passing it off as something else. Even in places where horseflesh is a popular food, chiefly in the form of a sausage, the vendors are required to indicate the nature of the article which they sell.

MEDICO-BIOLOGICAL SCIENCE IN THE ITALIAN UPPER CHAMBER.

AN Italian correspondent writes: "His Excellency Signor Giolitti, unlike many Italian premiers, has shown a marked preference for men of science in his selection of names proposed to the King for senatorial honours, nature study and medicine taking precedence of all other subdivisions of the field of knowledge. True to this tradition he has among the eight professors just promoted to the Upper Chamber included five whose distinction has been achieved in biology or medicine. They are the following: Dr. Pio Foà, professor of pathological anatomy in the University of Turin; Dr. Antonio Carle, professor of surgical anatomy and *privat-docent* in clinical surgery of the same

school; Dr. Giacomo Filippo Novaro, who holds the chair of operative surgery in the University of Genoa; Dr. Giovanni Paladino, professor of histology in the Neapolitan seat of learning; and Dr. Giovanni Battista Grassi, professor of comparative anatomy and entomology in the University of Rome, whose work in the "campagna anti-malarica" is well known throughout Italy and the English-speaking world. The Italian press comments approvingly on the reinforcement of the Senate by these authorities in their respective subjects, the future of Italy depending largely on the rehabilitation of her people hygienically as well as educationally and socially."

SUCCESSFUL OPERATION FOR PHLEGMONOUS GASTRITIS.

PHLEGMONOUS gastritis is a very rare condition of which only a limited number of cases have been published. In the *American Journal of the Medical Sciences* for May Dr. J. W. Bovée has published a case—probably the first—in which the suppurative form of the disease was successfully treated by laparotomy. A multipara, aged 36 years, was taken to hospital late on the night of Oct. 6th, 1907, by her medical attendant. For several years she had suffered from epigastric pain which was usually relieved by taking food. Her last period occurred on April 13th and she considered herself pregnant. On Oct. 3rd she ate heartily boiled cabbage at dinner and crab late at night. During the night she was attacked with severe pain in the gastric region which required the administration of morphine. On the following day the pain continued and vomiting began. Attempts to move the bowels by enemata and cathartics failed. The temperature ranged from 99·5° to 101·5° F. and the pulse was rapid and weak. On the next day croton oil was given but this also failed to act. Various remedies were administered to relieve the pain and vomiting, but without result. The vomit was at first solid and consisted of partially digested food. Later it was watery and frothy and dark green. On admission the pulse was thready and the expression was anxious. Examination under anæsthesia showed that the uterus extended an inch above the umbilicus and that the epigastrium was distended and tympanitic. An incision was made in the middle line above the uterus. The intestines were congested. The stomach was palpated and found to be fully three-quarters of an inch thick at the middle of the great curvature, gradually thinning towards the cardiac end. At the pyloric end and in front was a soft mass nearly of the size of a fist, which gradually thinned towards the middle of the stomach. The stomach was opened at about the middle by a longitudinal incision about three inches long and the mucosa was inspected. The pylorus would not admit the entrance of the tip of the little finger. In order to determine the nature of the enlargement a short incision was made over it. Gauze was packed around it and on incision two or three ounces of greyish pus escaped. The long incision in the stomach was closed, the abscess was wiped out, and a rubber tube was sutured in and brought out of the abdomen. A light gauze drain was packed about it. The patient was fed by the rectum for 21 days. Five days after the operation liquids were given by the mouth, as saline solution given hypodermically and liquids given per rectum did not quench the patient's insatiable thirst. On the following day the contents of the stomach came through the wound. A few days later solid food was given and the tube was removed. After a few days the contents of the stomach ceased to escape. On the eighth day abortion took place. Except for infection of the abdominal incision, which required resuturing, recovery was uninterrupted. Phlegmonous gastritis is characterised by the sudden onset of pain in the upper abdomen, which is increased by pressure, vomiting, rigors, and fever. If a tumour appears in the region of the stomach presumption of the disease becomes strong and if pus is vomited still stronger. In most cases a positive diagnosis is impossible. Excepting four cases the treatment has always been symptomatic, but the great progress of abdominal surgery will probably lead in the future to more frequent operation. The prognosis is bad; only two patients have been known to recover. In a case reported by Leith considerable peritonitis was present and the peritoneal cavity was washed out. Death occurred seven hours later. In a case recorded by Mr. A. W. Mayo Robson and Mr. B. G. A. Moynihan a gastric ulcer had eroded the pancreas and an abscess of that organ had burst into the stomach, causing acute gastritis. Posterior gastro-enterostomy was followed by recovery. In none of the recorded cases of operation was suppurative phlegmonous gastritis present, as in Dr. Bovée's case.

AN IMPENDING VISIT OF FRENCH MEDICAL MEN TO LONDON.

A MEETING took place at 20, Hanover-square, London, W., on June 4th, to discuss the question of giving a dinner in honour of the group of French medical men who are expected in England in July. Dr. Theodore Williams occupied the chair and explained that the impending visit was under the auspices of the "Voyages d'Études Médicales" which society had, on account of the Franco-British Exhibition, arranged an excursion to London in place of its annual visit to a French watering place. A number of resolutions were carried and it was arranged that a dinner should be given at the Exhibition on Thursday, July 16th, to 150 of our French visitors (ladies included). Those of the medical profession in England who wish to take part in this entertainment are asked to subscribe a sum of not less than 2 guineas to defray the cost of their own dinner and that of a French guest. A limited number of ladies will be included. The following executive committee was elected: Dr. G. Ogilvie, Dr. Leonard Williams, Dr. Leonard Mark, Dr. Dundas Grant (treasurer), and Mr. Macleod Yearsley. Gentlemen who wish to take this opportunity of showing hospitality to our French brethren are requested to communicate with a member of the committee without delay, as the banqueting accommodation at the exhibition is limited to 300.

LOCAL ANÆSTHESIA IN MINOR SURGERY.

THE interest in local anæsthesia which was initiated by the publication of Schleich's method of infiltration has steadily increased. There are many methods at present competing for general favour, infiltration, perineural injection with the use of a constricting band, intraneural injection, and modifications of the methods of Oberst, Braun, Krogius, and others. So there are also many local anæsthetics—cocaine, β eucaine, stovaine, alypin, and tropacocaine. The range of operations for which local anæsthesia has been used is ever widening. We may mention those involving skin areas, such as Thiersch's skin-grafting method, removal of superficial tumours, operations on the fingers and toes, removal of small mammary growths, ligature of arteries, extirpation of ganglia, and the more extensive procedures involved in operations upon the tongue, lips, trachea, ribs, and thorax. In some continental clinics goitres are commonly removed under local anæsthesia and besides the radical treatment of hernia abdominal operations of great magnitude have been conducted without using general anæsthetics. No doubt local anæsthesia presents many obvious advantages, and house surgeons, especially those in country infirmaries, will find benefit from acquiring a knowledge of its technique. There are, however, less obvious drawbacks and some reasons which have never been very fully advanced why the indiscriminate use of

local anæsthesia by house surgeons should be discountenanced. The technique is not so simple as appears and the best results can only be attained by the most heedful attention to detail. In the rush of hospital work, especially in places where skilled helpers are lacking, it is not easy to obtain that all-important adjunct to the use of local anæsthesia—sterilisation of instruments, of solutions, and of the skin. The time occupied by an operation performed under local as opposed to general anæsthesia is considerably increased, and this is not always unimportant. In cases in which a local œdema may extend into dangerous regions —e.g., the tongue—perils may arise before they are recognised. It cannot be insisted upon too strongly that success in local anæsthesia is obtainable only after much practice and watching the methods when employed by competent exponents. The extreme simplicity of the proceeding like that of injection into the subdural space is such when it is performed by an expert that the observer is prone to imagine that "there is nothing in it" and that anyone can obtain an equally good result. Undoubtedly both local and intrathecal injections afford most valuable aids, the former for minor surgery and both in those rare cases in which general anæsthesia seems contra-indicated. There is, however, a danger lest the methods should suffer by unwise or unskilful use in the hands of those who have failed to recognise that much knowledge, patience, and experience are needed for the success, or even safety, of local anæsthesia and of the lumbar puncture.

THE DRINK CRAVING.

A CASE was heard before the Manchester justices a few days ago which illustrates clearly one of the difficulties met with in attempting to reclaim the chronic drinker by detention in an inebriates' home, in the hope, of course, that after two or three years' abstention from drink the craving for it may be lost. The case was that of a middle-aged woman charged with drunkenness, and this, it was said, was her forty-first appearance before the court. She had been in the inebriates' home at Langho for three years, was said to be a splendid worker when not in drink and a very good laundress. The chairman said that the magistrates were disposed to send her for a further term of three years to the home. There was something pathetic in the woman's reply. "She had tried her best to keep off the drink, but it seemed she was always getting into the hands of the police." She said further that she did not suppose three years would do her any good, "because the being in a home upsets one's mind and makes you worse when you come out again." This will accord with the experience of many who have to deal with such cases. The craving is not lost but only rendered impossible of indulgence for the time being. There may be a sincere wish "to keep off the drink," but when the chain is loosed the weak will has no chance against the cruel, merciless craving which wrecks once more even her own hopes of escape from what seems an irresistible fate. There was some further dialogue between the chairman and the drunkard, the former saying, that if you go with a determination not to benefit "I dare say there is something in what you say," but if you make up your mind that it will be better for you and that when you come out you will turn over a new leaf, "then you will be all right." It is to be feared, however, that the chairman's well-meant counsel was prompted more by hope than experience, which latter would chime in rather with her answer, that "unless a man or a woman, under my circumstances, absolutely leaves drink alone, no punishment will benefit them. I have tried it, and I know." She was committed again for three years to Langho, but what will be the result of this further experiment? Putting aside the quack remedies for the drink craving, the ill success attending their use scarcely justifying their serious consideration, we are left apparently to one plan as being the most merciful to the victims themselves and their families, and most assuredly the best for society. This, of course, is permanent detention. It would have to be administered carefully and proper safeguards against abuse would be required, while the conditions justifying and requiring such detention would have to be most carefully and humanely considered. It is thought right to confine lunatics, no doubt with, in some cases, good hopes of benefit, but also as a protection from themselves and as safeguarding others. The same reasoning may be applied to these cases with equal fitness.

METROPOLITAN HOSPITAL SUNDAY FUND.

A MEETING of constituents of this Fund will be held on Monday next, June 15th, at 3 o'clock, at the Mansion House, London, the Right Hon. the Lord Mayor presiding, when a marble bust of the late Mr. George Herring, the munificent benefactor to the Fund, will be unveiled. The presentation will be made by the Hon. Sydney Holland (one of Mr. Herring's executors), while Bishop Lawrence of Boston, Massachusetts, and Mr. Henry Morris, President of the Royal College of Surgeons of England, will address the meeting in support of the objects of the Fund.

THE Cavendish lecture will be delivered before the West London Medico-Chirurgical Society on Friday, June 26th, at 8 15 P.M., by Sir William Whitla, M.A., M.D. R.U.I., LL.D., in the Town Hall, Kensington, London, W. The subject is the Etiology of Phthisis. The President of the society is Mr. R. Lake, F.R.C.S. Eng., and the honorary secretaries are Dr. F. G. Crookshank, D'Antraigues, The Terrace, Barnes, S.W., and Mr. A. Baldwin, F.R C.S. Eng., 6, Manchester-square, London, W., who are now sending out invitations to be present on the occasion and to whom any communications should be made.

THE annual banquet of the Association of British Postal Medical Officers "to meet the Right Hon. Sydney Buxton, M.P., His Majesty's Postmaster-General," will be held at the Whitehall Rooms of the Hôtel Métropole on Tuesday, July 14th, at 7.30 P.M. The President, Dr. George A. Mason. M.A. Camb., will occupy the chair. The secretary of the dinner is Dr. R. Ritchie Giddings, Hillsborough House, Mansfield-road, Nottingham.

THE annual general meeting of the Medical Officers of Schools Association will be held at 11, Chandos-street, W., on Wednesday, June 17th, at 3.30 P.M., when Mr. John Hayward will open a discussion on the recent memorandum issued by the Board of Education to local education authorities *re* the medical inspection of elementary schools.

THE Governor of Hong-Kong has stated in a despatch to the Secretary of State for the Colonies that 133 cases of plague with 109 deaths were reported during the week ending June 1st. In the previous week 114 cases with 95 deaths were reported from that colony.

THE INTERNATIONAL FIRST AID CONGRESS.—The exhibition which is being held in connexion with the International First Aid Congress at Frankfort-on-Main was opened on June 6th. The first-aid section of the exhibition includes a large number of appliances which cannot fail to attract the attention of everyone interested in the humane work which the exhibits illustrate. Particular interest is shown by visitors in an improved rocket apparatus which is described as an aerial torpedo for life-saving at sea, for use from either shore to ship or from ship to shore. It consists of a line 500 yards in length, carried by a torpedo four inches in diameter and 20 inches in length. Its chief features are its portability and the ease and accuracy with which it can be manipulated.

MEDICINE AND THE LAW.

Insanity a Bar to Valid Marriage.

THE case of Jackson *v.* Jackson recently heard by Mr. Justice Bargrave Deane in the Divorce Court was a wife's suit for nullity of marriage on the ground that at the time of the marriage her husband was suffering from paranoia or delusional insanity and incapable of contracting marriage. The facts were as follows: Catherine R. Jackson, *née* Macfarlane, went through a ceremony of marriage on Oct. 8th, 1904, with H. P. M. Jackson, at St. Luke's Church, Kensington. There was a child born on Oct. 25th, 1905. It appeared that since the respondent had returned from the South African war in 1902 he had been subject to delusions, the main ones being that there was a conspiracy or plot to injure him, that his letters were being tampered with, that he was impotent, and that he constantly heard voices. It was not disputed that he went through the ceremony as an ordinary individual would have done, but during the honeymoon in Italy the delusions gradually became more marked, and he also then alleged that his wife had been unfaithful. On March 18th, 1905, Mr. Jackson was certified as insane and was removed to a private asylum. On behalf of the respondent it was urged that the delusions were not such as to affect his capacity to enter into a contract of marriage. Mr. Justice Bargrave Deane in giving judgment said that there were a number of cases which must guide the court but that each case must in a great measure depend upon its own facts. The principle running through the cases was to the effect that the court must take into consideration the nature of the alleged unsoundness of mind and see whether it was of sudden or progressive growth. When the unsoundness of mind had been proved to be progressive a decree had been granted. In the present case it was, therefore, necessary to see how far back the insanity could be traced. The law was clearly laid down in Hunter *v.* Edney by the late Lord Hannen who said: "The question which I have to determine is not whether the respondent was aware that she was going through the ceremony of marriage, but whether she was incapable of understanding the nature of the contract she was entering into, free from the influence of morbid delusions upon the subject." His lordship referred to the evidence of the respondent's conduct on his honeymoon in Italy, and continued: While on the continent the respondent complained that he was being watched, spied upon, and that signals and signs were being made about him, and that everybody was laughing at him owing to his impotency. That last delusion was a very material one because the evidence showed that it had existed before marriage as well. It was possible for a man to have such an opinion before marriage but there could be no such delusion after. In the present case the delusion continued, for even after the petitioner had informed him that she was *enceinte* he still expressed the belief that he was impotent. After their return to England the disease had so progressed that the respondent was certified as insane and had been pronounced incurable. The eminent alienists who had been called agreed that "paranoia" was incurable and a disease of progressive growth. One of the experts had expressed as his opinion that the disease in the present case dated from the return of the respondent from South Africa. It was therefore for the court to determine whether the respondent was on Oct. 8th, 1904, capable of understanding the nature of the contract he was entering into, free from the influence of morbid delusions upon the subject. The burden of proof was on the petitioner, and in his opinion she had succeeded and had clea ly established that the respondent's disease was of gradual growth and had existed long before the parties became acquainted. Therefore there would be a decree *nisi* of nullity. It may be added that insanity or want of reason is a bar to marriage on the ground that without consent there can be no contract, and that where there is no reason there is no power of consent. Mere weakness of understanding is not enough, but there must be proof of incapacity to enter into the contract, the extent of the incapacity being a question of fact to be proved by evidence which to a large extent in such cases must be that of medical experts. A person on recovering sanity may institute proceedings to set aside a marriage entered into when *non compos mentis*, and if insanity at the time of the formation of the contract is proved the marriage will be declared void.

Casual Employment under the Workmen's Compensation Act.

A point of importance under the Workmen's Compensation Act, 1906, made clear by a recent decision of the Court of Appeal, is worth noting by medical practitioners. The wife of a member of the Stock Exchange employed a man to clean windows at their residence and he, while doing so, fell and was killed. The claim against the stockbroker made by those dependent on the deceased workman was resisted on the ground that he was a person casually employed only and not one of those so employed who are entitled to the benefit of the Act which does not include under the term workman "a person whose employment is of a casual nature and who is employed otherwise than for the purposes of the employer's trade or business." The Master of the Rolls in giving judgment pointed out that the employer, a stockbroker, could not be held to be employing a man for the purpose of his business who was only engaged to clean the windows at his private house and said that he interpreted the Act as intended to benefit a workman employed by another for the purpose of that person's trade or business in spite of the fact that such employment was casual only but that it was essential that the employment should be for the purpose indicated. A good many people, no doubt, insure against accidents happening to those whom they may employ casually, with a view to protecting themselves in the event of claims being made by window cleaners, charwomen, luggage porters, and the like. If they do employ such persons but not for any trade or business purpose, having perhaps no trade or business, they are not legally liable for accidents happening to them. At the same time it must be remembered that claims, though baseless, may yet be made, that the employer may have some difficulty in resisting them, and that he may require legal aid in doing so. It may therefore be prudent to insure in respect of accidents that may happen to a casual workman, although there may be no apparent liability, in order to have the assistance of the insurance company in defeating a possible claim which in no case should succeed. In the instance referred to above compensation had been allowed in the county court and in the Court of Appeal the employer had the assistance of very eminent counsel. This question of accidents to casual workmen affects medical men in particular, because the premises in which they exercise their profession are usually part of, or connected with, their homes, and the casual workman may be engaged at one moment upon work for the purposes of the trade or business of his employer and at another upon something quite independent of it, and the employer's liability will vary accordingly. For example, a window cleaner falling and injuring himself when cleaning the window of a consulting room can apparently enforce a right to compensation which he would not possess after a similar accident due to cleaning the window of the drawing-room, and we can imagine a severe legal fight on the point under discussion arising out of such an accident if the man fell while cleaning the dining-room window, and if it was proved that that apartment was sometimes used for meals and sometimes as a waiting room for patients. The necessity for insuring against accidents to casual workmen is therefore one peculiarly affecting medical practitioners.

Looking Back.

FROM

THE LANCET, *SATURDAY*, June 12th, 1830.

PROTRACTION OF VEGETABLE LIFE.

THE following extraordinary instance of the lengthened period of time during which the vital principle of vegetables may be preserved, was mentioned by Mr. Houlton in the course of his introductory lecture as professor of botany, at the last meeting of the Medico Botanical Society. A bulbous root, which was found in the hands of an Egyptian mummy, and in which situation it had very probably been for more than two thousand years, germinated on exposure to the atmosphere, though, when discovered, it was apparently in a state of perfect dryness. The root was subsequently put into the ground, where it grew with readiness and vigour.

LYNN THOMAS AND SKYRME FUND.

THE following subscriptions have been received between May 29th and June 5th by Mr. William Sheen, M.S. Lond., F.R.C.S. Eng. (2, St. Andrew's-crescent, Cardiff), honorary secretary to the fund.

Subscribers of Seventeen Pounds Thirteen Shillings and Sixpence.

Westminster Division of the British Medical Association, per Harvey Hilliard. (Full list of names will be published next week.)

Subscribers of Ten Guineas.

Clinical Society of Manchester, per Gordon Fitzgerald.

Subscriber of Five Pounds.

Anonymous.

Subscribers of Four Pounds Twelve Shillings.

Blackburn Division of the British Medical Association, per Howard Henry, the amount being made up as follows:—

Half-a-Guinea from—

J. T. Ballantyne.
M. Bannister.
E. D. S. Heyliger.
F. W. Taylor.

Ten Shillings from—

John Barr
William Moir

Five Shillings from—

Dr. Arnold.
Andrew Baxter.
Dr. Geddie.
Howard Henry.
T. T. Maclin.

Half-a-crown from—

J. W. Miller.
E. M. Payne.

Subscribers of Four Pounds Five Shillings.

Wigan Medical Society, from some of the Members, per John Blair.

Subscribers of Three Pounds Three Shillings and Sixpence.

Portsmouth District of Southern Branch of the British Medical Association, per B. H. Mumby.

Subscriber of Two Guineas.

John W. Stephens, Cardigan.

Subscribers of One and a Half Guineas.

Wolverhampton Branch of the British Medical Association, per J. Alfred Codd, being half a guinea each from the following—

Anon.
J. T. Harthill.
H. Malet.

Subscribers of One Guinea.

Thomas Baker, Waterlooville, Cosham, Hants.
R. A. Cowie, Ebbw Vale, Mon.
Mark Jackson, Purley.
Edgar Haydon, Newton Abbot.
G. W. Homan and F. W. Rowland, Lichfield.
James Hussey, Farnham, Surrey.
E. R. Williams, Carmarthen.
S. Wallace, Cardiff.

Subscriber of Half-a-Guinea.

W. Macphail, Coatbridge, N.B.

Subscriber of Ten Shillings.

John Jones, Dolgelly.

Subscriber of Five Shillings.

William Cash Reed, Liverpool.

Subscriber of Half-a-Crown.

A Friend.

SOCIETY FOR RELIEF OF WIDOWS AND ORPHANS OF MEDICAL MEN.

THE annual general meeting of this society was held on May 14th at 11, Chandos-street, Cavendish-square, Dr. G. FIELDING BLANDFORD being in the chair. Seven directors were elected to fill the vacancies in the court. A cordial vote of thanks was passed to the editors of the medical journals who from time to time publish notices of the society.

The report for 1907, which was adopted, stated that during the past year 11 new members were elected and ten died. The society consists at the present time of one honorary member, 144 life, and 144 paying members, making a total of 289, which, considering the number of medical men who are eligible for membership, is but a very small proportion. The invested funds amount to £99,260, from which is derived in interest the sum of £3118 2*s.* 5*d.*; £433 0*s.* 3*d.* were received in subscriptions and donations. Amongst the annuitants of the charity—namely, 49 widows and 17 orphans—the sum of £3151 10*s.* was distributed. 43 widows received £50 each, four £40, one £30, and one £25 with £10 extra at Christmas, and each orphan £12 and £3 extra at Christmas.

The Copeland Fund is a special fund which enables the society to grant to any widow or orphan already in receipt of the society's ordinary relief, extraordinary relief in special circumstances of unusual distress such as blindness, paralysis, insanity, severe disabling accident, or grave permanent disease, and to continue such extra relief in the case of orphans beyond the age of 16 or 18 years (at which, under the society's existing by-laws, the ordinary relief ceases) for such further period as the court of directors may think fit.

During the year two widows in receipt of grants died. One, whose husband had paid in subscriptions £26 3*s.*, had received £490, and the other, whose husband had paid in annual subscriptions £27 6*s.*, had received £2824: she had been in receipt of grants since 1866. Two widows were elected during the year, and on Dec. 31st there were 48 widows and 16 orphans in receipt of grants. One of the widows has been on the books since 1854 and has already received over £2060. Relief is only granted to the widows and orphans of deceased members who have paid their annual subscription for three years or who are life members. During the year nearly 50 letters were received from widows of medical men, who, in many instances, had been left practically penniless, asking for relief, but this had to be refused as their husbands had not been members of the society.

The directors cannot too strongly urge upon the members of the medical profession, especially the younger ones, the desirability of joining the society. Membership is open to any registered practitioner who at the time of his election is resident within a 20-mile radius from Charing Cross. Should any member remove beyond the limits of the society he nevertheless continues to be a member.

The annual subscription is 2 guineas; every member who has paid this sum for 25 years becomes a member for life. Life membership may also be obtained by the payment of one sum, varying with the age of the applicant. Further particulars and application forms may be obtained from the secretary at the offices of the society, 11, Chandos-street, Cavendish-square, London, W.

The meeting closed with a vote of thanks to the chairman.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

IN 76 of the largest English towns 8731 births and 3958 deaths were registered during the week ending June 6th. The annual rate of mortality in these towns, which had declined in the four preceding weeks from 14·2 to 12·6 per 1000, rose slightly to 12·7 in the week under notice. During the first ten weeks of the current quarter the annual death-rate in these towns averaged only 14·4 per 1000, and in London during the same period it did not exceed 14·0. The lowest annual death-rates in the 76 towns during the week under notice were 6·4 in Walsall, 6·9 in Handsworth (Staffs), 7·4 in Aston Manor, 7·9 in Bury, 8·5 in Tynemouth, 8·9 in Reading, and 9·0 in Hornsey; the rates in the other towns ranged upwards to 17·4 in Grimsby, 17·7 in Stockton-on-Tees, 19·4 in Stockport, 19·9 in Hanley, 20·9 in Merthyr Tydfil, and 24·5 in Swansea. The death-rate in London during the week did not exceed 11·6. The 3958 deaths in the 76 towns during the week showed a further decline of 185 from the numbers returned in the four preceding weeks, and included but 354 which were referred to the principal epidemic diseases, against numbers declining from 445 during the nine preceding weeks; of these 354 deaths, 103 resulted from whooping-cough, 83 from measles, 67 from diarrhœa, 45 from diphtheria, 33 from scarlet fever, and 23 from "fever" (principally enteric), but not one from small-pox. The deaths from these epidemic diseases last week were equal to an annual rate of 1·1 per 1000, against 1·2 per 1000 during the nine preceding weeks; the rate from these diseases in London did not exceed 0·9 per 1000. No death from any of these epidemic diseases was registered last week in Willesden, Walsall, Huddersfield, St. Helen's, or in nine other smaller towns; the annual death-rates from these diseases ranged upwards, however, to 2·6 in Reading, 2·7 in Preston, 3·4 in Norwich and in Merthyr Tydfil, and 3·9 in Stockton-on-Tees. The fatal cases of whooping-cough in the 76 towns, which had been 114 and 75 in the two preceding weeks, rose to 103 last week; this disease caused the highest death-rates, 1·5 in Smethwick and in Burnley, 1·7 in Barrow-in-Furness, and 2·2 in Warrington. The deaths from measles, which had been 100 and 72 in the two preceding weeks, rose to 83 in the week under notice, the highest rates being 1·3 in Preston, 1·6 in Rhondda, and 2·9 in Stockton-on-Tees. The 67 deaths from diarrhœa was the highest weekly number this

year; the mortality was highest in Hanley, Middlesbrough, and Merthyr Tydfil. Of the 45 deaths from diphtheria, which showed an increase upon the numbers registered in the five previous weeks, 13 occurred in London and three in Salford. The 33 deaths from scarlet fever showed a slight decline compared with the numbers in the two preceding weeks and included ten in London and two in Tottenham, in Reading, in Grimsby, in Liverpool, and in Bradford. Three of the 23 deaths from "fever" were registered in London and three in Norwich. The number of scarlet fever patients under treatment in the Metropolitan Asylums and the London Fever Hospitals, which had declined from 2938 to 2753 in the five preceding weeks, further declined to 2648 on June 6th; 291 new cases were admitted to these hospitals during the week under notice, against 330 and 334 in the two preceding weeks. The deaths in London referred to pneumonia and to other diseases of the respiratory organs, which had steadily declined from 301 to 147 in the six preceding weeks, further fell to 132 during the week under notice, and were 37 below the corrected number in the corresponding week of the five years 1903–07. Only nine deaths were directly referred to influenza in London, showing a marked decline from recent weekly numbers. The causes of 39, or 1·0 per cent., of the deaths registered last week in the 76 towns were not certified either by a registered medical practitioner or by a coroner. All the causes of death were again duly certified in Leeds, Manchester and Salford, Bristol, West Ham, Bradford, and in 52 other smaller towns; eight uncertified causes of death were, however, registered in Liverpool and seven in Birmingham.

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in eight of the principal Scotch towns, which had been equal to 15·4 and 15·5 per 1000 in the two preceding weeks, declined to 14·3 in the week ending June 6th. During the first ten weeks of the current quarter the annual death-rate in these eight towns averaged 17·1 per 1000, and exceeded by no less than 2·7 the mean rate during the same period in the 76 large English towns. Among the eight Scotch towns the death-rate during the week under notice ranged from 12·3 in Leith and 13·3 in Paisley to 16·0 in Greenock and 16·7 in Dundee. The 503 deaths in the eight towns (against 542 and 546 in the two preceding weeks) included 30 which were referred to the principal epidemic diseases, showing a further decline upon the low numbers returned in the two preceding weeks; of these 30 deaths, 10 resulted from whooping-cough, five from measles, five from diphtheria, five from diarrhœa, three from "fever," and two from scarlet fever, but not one from small-pox. These 30 deaths were equal to an annual rate of 0·9 per 1000, the mean rate from the same diseases in the 76 English towns during the same week being 1·1. The 10 deaths from whooping-cough showed a decrease compared with those in the two preceding weeks; five of these deaths were registered in Edinburgh and three in Dundee. The five fatal cases of measles were the lowest in any week during the present year; four were returned in Glasgow and one in Edinburgh. The five deaths from diphtheria, equal to the number returned last week, belonged to Glasgow. The five deaths from diarrhœa were considerably below the average; two cases were registered in Dundee. Of the two deaths from scarlet fever, one occurred in Glasgow and one in Paisley. One death from enteric fever was registered in Edinburgh, and one from enteric fever and one from cerebro-spinal meningitis in Glasgow.

HEALTH OF DUBLIN.

The annual rate of mortality in Dublin, which had been equal to 22·2 and 15·9 per 1000 in the two preceding weeks, rose to 16·5 in the week ending June 6th, and with the exception of last week was lower than in any previous week of this year. During the first ten weeks of the current quarter the death-rate in Dublin averaged 21·3 per 1000; the mean rate during the same period did not exceed 14·0 in London and 15·8 in Edinburgh. The 125 deaths of Dublin residents registered during the week under notice showed an increase of five over the number returned in the previous week, and included nine which were referred to the principal epidemic diseases, against four and six in the two preceding weeks. These nine deaths were equal to an annual rate of 1·2 per 1000, the rate during the week from the same causes being 0·9 in London and 1·2 in Edinburgh. Of the nine deaths from these epidemic diseases in Dublin, three resulted from measles, two from diphtheria, and one from scarlet fever, one from whooping-cough, one from "fever," and one from diarrhœa, but not one from small-pox. The 125 deaths from all causes in the city during the week under notice included 26 of infants under one year of age and 28 of persons aged upwards of 60 years, the deaths of elderly persons being considerably fewer than in any previous week of this year. Four inquest cases and two deaths from violence were registered, and 61, or 48·8 per cent., of the deaths occurred in public institutions. The causes of all but four of the deaths during the week were duly certified. The causes of all but three of the 1068 deaths in London were also duly certified, but more than 5 per cent. of the causes of death in Edinburgh were uncertified.

THE SERVICES.

ROYAL NAVY MEDICAL SERVICE.

In accordance with the provisions of Her late Majesty's Order in Council of April 1st, 1881, Inspector-General of Hospitals and Fleets William Edward Breton has been placed on the Retired List at his own request (dated May 30th, 1908); and Surgeon Alexander Cameron Renwick has been allowed to withdraw from His Majesty's Naval Service with a gratuity (dated June 4th, 1908).

In accordance with the provisions of His Majesty's Order in Council of August 11th, 1903, Surgeon John Shipsey has been allowed to withdraw from the Royal Navy with a gratuity.

The following appointments are notified:—Surgeons: P. D. Ramsay to Gibraltar Hospital and Aloysius F. Fleming to the *Vivid* for Royal Naval Barracks.

ARMY MEDICAL SERVICE.

Surgeon-General Richard H. Quill is placed on retired pay (dated June 8th, 1908).

DEATHS IN THE SERVICES.

Surgeon-General Sir James Arthur Hanbury, A.M.S., K.C.B., on June 3rd at Bournemouth in his 77th year. He entered the service in 1853 as assistant-surgeon, was made surgeon in 1863, surgeon-major in 1873, deputy-surgeon-general in 1881, and surgeon-general in 1887. He retired in 1892. He served in the Afghan war of 1878–80, and took part with the expedition into the Bazar Valley (mentioned in despatches), accompanied Sir Frederick Roberts in the march to Candahar, and was present at the battle of Candahar (mentioned in despatches, C.B., medal with clasp, and bronze decoration). Served in the Egyptian war of 1882 as principal medical officer, and was present at the battle of Tel-el-Kebir (twice mentioned in despatches, K.C.B., medal with clasp, 2nd class of the Medjidieh, and Khedive's Star).

THE BRITISH RED CROSS SOCIETY.

Notice is given in the *London Gazette* that a petition of Her Majesty the Queen and the Right Honourable Lord Rothschild, G.C.V.O., praying for the grant of a Charter for the incorporation of the British Red Cross Society, has been presented to His Majesty in Council; and His Majesty having referred the petition to a committee of the Lords of the Council, further notice is given that all petitions for or against such grant should be sent to the Privy Council Office on or before the sixth day of July, 1908.

NAVAL VICTUALLING.

The *Times* of June 9th in an article from a correspondent states that: "The victualling and canteen arrangements introduced into the navy on October 1st last have, after six months' working, proved an unqualified success as far as the men are concerned, and it is claimed that they will save no less than £500,000 on the first year's working. ..... Those who took a leading part in bringing about these reforms hoped that not only would a saving be effected for the men of the navy but also for the State; so far this latter hope has met with disappointment. ..... There is, however, a more unsatisfactory feature from the national point of view. Tea, which is admittedly of very fine quality, can be purchased for 1*s.* per pound, sugar at 2*d.*, and fresh meat at 4*d.*; this is creating an unhealthy market for these articles at the home ports, and though there

may be no loss to the Government on the sale of the two former articles the traffic is vicious and will tend to grow unless checked. On meat, however, there must be a loss, as from market quotations the Admiralty must be paying from 6*d.* to 7*d.* per pound for it; to retail it at 4*d.* per pound with permission to take it on shore seems to be a mistake. This privilege of taking meat on shore is a very old one and few would like to see it stopped in the case of married men who really require it for their own consumption, but the privilege was never intended to extend into a traffic."

Surgeon-General W. Simson Pratt, C.B., A.M.S., principal medical officer, Southern Command, made his annual inspection of the Devonport Military Hospital and Military Families Hospital on June 2nd. He was accompanied by Lieutenant-Colonel H. G. Hathaway, R.A.M.C., and Colonel W. J. Read Rainsford, C.I.E., R.A.M.C. Surgeon General Pratt inspected Okehampton Camp (Devon) on June 4th.

Correspondence.

"Audi alteram partem."

AUSTRALIA FOR THE SONS OF PROFESSIONAL MEN.

To the Editor of THE LANCET.

SIR,—It is a good many years since I resided in Great Britain, but even then the problem of "what to do with our boys" pressed heavily upon the parents of the professional classes. The army and navy were closed to those who had no private income, the clerical, legal, medical, and other professions were overstocked, and the openings in commerce were only for those who had money or influential connexions. And everything that I can learn points to an intensification of these conditions at the present day. The position, therefore, of the man who has sons about to leave school must be a very difficult one, when he is face to face with the question of how to give them a satisfactory start in life. It is the hope of being able to do something to answer this question which prompts me to beg for some space in your columns.

For years, many of the sons of professional men have emigrated to the United States or Canada. I come forward with the claim that Australia and New Zealand can offer opportunities superior to either of these two countries to industrious and persevering lads, who are prepared to accept rough and strenuous conditions for the sake of obtaining a competence in later life. I may say at once that there are no openings in our large towns. All the city occupations are filled to overflowing. But the Australian bush is calling for thousands of willing hearts and hands to subdue it and make it fruitful. The wealth of Australia is immense and this is mostly due to the production of wool, wheat, sugar, butter, live stock, and fruit commodities, for which there is a great and growing demand, at prices that are likely to be maintained or increased. Life on the land therefore promises to him who approaches it in a spirit both scientific and practical the opportunity not only for a healthy and natural existence but the possibility of an independence. The glorious climate of Australia is all in its favour. Here there is no long rigorous winter. A man can work and stock graze in the fields all the year round. Much has been said about the Australian droughts, but it is not generally known that there are wide districts where drought is practically unheard of. And the conservation of fodder and the great irrigation schemes which are being carried out will henceforth rob the occasional droughts of much of their terror. In New South Wales there has been only one total failure of the wheat crops in 17 years.

I do not for a moment suggest that lads should be sent out here with some money to take up land for themselves straight away. This would simply spell disaster. What I propose is that the lad who has decided to make Australia his home should adopt one of three courses:—

1. He should enter as a student at one of the Government agricultural colleges, where, for about £30 a year, he will receive a thorough training in scientific and practical farming. The sum quoted includes board and lodging, both of which I can guarantee to be excellent—quite as good as, if not better than, that provided at any English public schools. At the end of his two years' course there he could take up land for himself or spend another year in gaining experience with a practical farmer before launching out for himself.

2. He could be placed, as far as New South Wales is concerned, with a farmer holding high qualifications as a teacher of agriculture, who for £12 a year and his labour would give him a training almost as good as that he could obtain at a college. I am again prepared to guarantee that any lads intrusted to this man would be properly looked after and instructed.

3. The third alternative is that he could go to a Government farm for three months and receive, free of cost, instruction in milking, ploughing, and the care of horses, pigs, &c. At the end of this time his services would be of sufficient value to enable him to be placed with a respectable farmer who would pay him about 10*s.* a week and his board, and would increase his wages gradually to 15*s.* or 20*s.* After an apprenticeship of this kind for a year or two he would be fitted to start on his own account.

These three avenues to the land are open to all and there exists a voluntary organisation here, the Immigration League of Australasia, whose chief object is to welcome new-comers and afford them advice and assistance. The executive committee are prepared to give information about Australia and New Zealand to all who write to them, to arrange for the placing of lads at agricultural colleges or farms, to act generally *in loco parentis* towards them, and to see that they are not taken advantage of in any way. The league numbers among its members some of the leading men of Australia, and their desire is to help in the development of the continent and retain the British emigrant under the flag of Empire.

We say, send your sons to us and we will insure them proper treatment and a fair start. We do not want ne'er-do-wells or failures. Experience proves that such do no better here than in the old country. But steady, industrious lads are bound to succeed here and in many cases their parents might be induced to follow them out here and prolong their lives in this incomparable climate. We invite parents to communicate with us at Bull's Chambers, Moore-street, Sydney, Australia, and we will give them full information and send books and maps about Australia and New Zealand and prospectuses of agricultural colleges and schools of mines. Some months' notice is needed to enable a lad to be entered at an agricultural college.

I am, Sir, yours faithfully,

RICHARD ARTHUR, M.D. Edin.,
President, Immigration League of Australasia.

*** It seems to us a grave reflection upon our politicians, all parties alike being referred to, that England, Ireland, and Scotland should offer no advantages, commensurate with those offered by Australia, New Zealand, and Canada, to those who wish to follow agriculture as a career. There are in all three divisions of the United Kingdom large tracts of land—only not regarded as large because of the inevitable comparison with the vast acreage of the colonies mentioned—which would repay farming, at any rate "intensive" farming, but which at present are almost out of cultivation, and these tracts are contiguous to thickly populated cities. That labour and produce are not forthcoming from them upon terms profitable alike to the public, the employer, and the employed is a standing indictment of our rulers. But the home conditions being what they are we can only commend Dr. Arthur's letter to the attention of any of our readers who have sons to bring up.—ED. L.

MR. CORONER TROUTBECK AND DEATHS AFTER OPERATIONS.

To the Editor of THE LANCET.

SIR,—The coroner's office is a very ancient one and has no doubt in its time done useful work in promoting the public welfare. None the less there are not wanting some among us who regard its survival as an anachronism, its machinery cumbrous and antiquated, and think that the public safety might be quite as efficiently protected in a simpler and less expensive manner. If all the coroners in England and Wales were to tread in the footsteps of Mr. Troutbeck it is not unlikely that the number of those holding such views would be much augmented. Last week an inquest was held in South-West London on Gertrude Helen Muirhead, a teacher of music, who was the patient of an eminent London

surgeon, and unfortunately died a short time after an operation performed to relieve a necessarily fatal disease. The operator attended and after giving evidence expressed his surprise that an inquest had been held on the case; but Mr. Troutbeck is reported to have said: "That it was the opinion of all coroners in England that if an operation was a material part of the cause of death an inquest must be held," and he further stated that "it was impossible to dissociate the operation entirely from this woman's death." What is meant exactly by "a material part of the cause of death" might furnish matter for a very nice argument, but it would be interesting to know if all the coroners in England agree with Mr. Troutbeck in his sweeping definition that it is a material part of the cause of death when it cannot be dissociated from the cause of death. If they do, it is perhaps fortunate for the public that they do not act up to their opinion.

In nearly all cases where deaths follow after operations it would be impossible to dissociate the operation entirely from the cause of death, so that it would practically mean the holding of an inquest on every death after an operation. If such a course were adopted it would be a fatal bar to all progressive surgery, and it is shocking to contemplate the probable effect it would have in increasing the sum of human misery. Few operations would be performed where any risk was involved, and palliative operations would rarely, if ever, be done. Great enough in all conscience is the worry and anxiety that every surgeon has to undergo after a serious operation, and to have superadded to it the knowledge that if the result is unfortunate he will be required to justify all the details of the operation before a dozen ignorant jurors, presided over by a coroner possibly in this respect equally ignorant, is a prospect that few surgeons could view with equanimity.

I am, Sir, yours faithfully,

MAJOR GREENWOOD, M.D. Brux., LL.B.,
Barrister-at-Law.

June 5th, 1908.

THE GRAND DUCAL HESSIAN STATE AND THE ST. GEORGE'S-NAUHEIM INSTITUTE.

To the Editor of THE LANCET.

SIR,—There have recently appeared in the lay press notices relating to an injunction which was by consent granted against this institute at the suit of the Hessian Government. As such notices in their abbreviated form and in the absence of an explanation are calculated to cause an entirely erroneous impression regarding an institution of which, in conjunction with my colleague, Mr. W. de Marchot Hill, I am in charge, I ask of your courtesy to insert this letter in your widely read paper. This institute has been under my control for the past few months, and whilst disclaiming any responsibility for the action of the directors before my connexion with the institute I feel that it is due to my colleague, myself, and those of my profession who have so cordially supported me that an explanation of the very misleading paragraphs that have appeared in the leading daily journals should be given. The injunction was, *inter alia*, to restrain the St. George's-Nauheim Institute from representing that they were the agents of the Hessian Government, from using the Hessian arms, from representing their business as a branch of the Government, and from using the name Nauheim without clearly distinguishing the baths of the institute from those of the Government.

From the fact that the injunction was consented to it might be inferred that the St. George's Institute had wrongfully committed all these acts, but as a matter of fact Mr. Cosens Hardy, who represented this institute at the trial, particularly repudiated such a state of affairs and agreed to the injunction because it necessitated absolutely no change in any detail whatsoever in the present conduct of the institute. Mr. McNaughton, K.C., on behalf of the Hessian Government, stated that the directors of the St. George's Institute had claimed that the Nauheim system can cure every malady that flesh is heir to. Although in no way connected with, or responsible for, the statements referred to, I should like to point out that the list of ailments published by the directors of the institute is identical with that published by the Society of Physicians at Bad Nauheim in their prospectus, so that it would appear that the Hessian authorities are complaining of the act of their own Society of Physicians.

Personally, I think most medical men will agree with me in supporting the Hessian Government in their condemnation of this extraordinarily prolific list of diseases. At all events, since taking charge of the institute I have very much curtailed the list of indications. As for many months past the institution has been conducted on methods above reproach and approved by many of the leading physicians and medical journals, this short explanation will suffice to remove any doubts that may have been raised by the reports in the lay press. Trusting that I have not encroached too much on your patience and space,

I am, Sir, yours faithfully,

W. BAIN, M.B., B.S. Lond.

George-street, Hanover-square, London, W., May 28th, 1908.

TANSINI METHOD FOR THE CURE OF CANCER OF THE BREAST.

To the Editor of THE LANCET.

SIR,—I have read in THE LANCET of March 28th a critical letter from Mr. W. Sampson Handley about the Tansini method for the cure of cancer of the breast. I do not understand the allusion to the deep band, as by Tansini's method it can be removed more easily than by any other method without extensive dissection, which is to be avoided both from the point of view of the patient and of the technical excellence of the operation. Perhaps on account of the shortness of my note I did not insist sufficiently on what is, for the most part, well known, that even with more radical methods recurrence in the skin is often observed in the immediate neighbourhood of the scar. I have often observed a recurrence in the skin when by the ordinary methods it has not been removed freely enough owing to anxiety to obtain direct union of the wound. It is necessary to remove as much skin as possible; it is especially on this account that Professor Tansini devised his plastic operation, and he was not alone in thinking it necessary to have recourse to such a measure as a remedy for the removal of the skin. Others have proposed to obtain the flap from the skin near the wound left by the operation or to fill this up by transplanting the breast of the opposite side. Professor Tansini has devised a very rational plastic procedure which offers other advantages which I have already mentioned. All surgeons recognise the necessity of extensive removal of the skin and we cannot affirm that it is possible to join the flaps direct if all the skin of the breast has been cut away. If it be objected that the cutting of the flap makes the operation a little more complicated it must be borne in mind that in any case the operation is a very serious one, that relapses are frequent, that as a rule, at least in Italy, patients come to be operated on with the disease advanced, and that the statistics have improved since extensive removal of the skin has been performed. Unless this principle, which is now generally accepted, be abandoned I must persist in recommending the Tansini method as one worthy of being widely known and employed.

I am, Sir, yours faithfully,

Pavia, June 1st, 1908. Prof. FRANCESCO PURPURA.

THE ADMINISTRATION OF VACCINES BY THE MOUTH.

To the Editor of THE LANCET.

SIR,—Dr. Clive Riviere, in THE LANCET of June 6th, states that it is impossible to prove that tuberculin and other vaccines are absorbed when administered by the mouth in a disease such as pulmonary tuberculosis, as he holds that "in this disease auto-inoculation is continually going on and the opsonic index is continually fluctuating." He therefore asks for proof of absorption in cases of localised disease with a stationary index. I do not agree with his argument or with his conclusion, but gladly supply the proof he requires. Chart 31 (showing indices of 1·3 and 1·4) in the paper[1] referred to by Dr. Riviere is an example of the effect of the oral administration of tuberculin in a case of localised infection of glands in which the index had been 0·6 or 0·7 for several days before tuberculin was prescribed. Chart 15 is an example of the absorption of staphylococcic vaccine when given by the mouth. In this instance the index fell from

[1] Proceedings of the Royal Society of Medicine, Medical Section, vol. i., No. 6, p. 195, April, 1908.

1·1 to 0·8 immediately after the administration of the vaccine and subsequently rose to 1·5.

I am, Sir, yours faithfully,

Portland-place, W., June 9th, 1908. ARTHUR LATHAM.

A DISCLAIMER.

To the Editor of THE LANCET.

SIR,—A friend of mine who is a dentist has drawn my attention to a pamphlet entitled "The Contemplated Medical Anæsthetists Bill." It is signed by Mr. Robert Marston. In this it is implied that I am to give a demonstration concerned with chloroform for a stake of £5 a side! It appears a grotesque assumption that I should lend myself to such a proceeding, but as the pamphlet has been scattered broadcast I am compelled to say that my name has been used without my permission, and I have no intention of countenancing any demonstration of the kind. I shall be obliged to you for giving publicity to this statement.

I am, Sir, yours faithfully,

Mortimer-street, W., June 9th, 1908. DUDLEY W. BUXTON.

"THE OLDEST INSTITUTION FOR TREATING SICK CHILDREN."

To the Editor of THE LANCET.

SIR,—To prevent misconception such as has occasionally arisen in the past and which might arise again in the future from the recent letter to the papers from the secretary of the Royal Waterloo Hospital, may I ask you to state that the first hospital for sick children to be established in this country was the Hospital for Sick Children, Great Ormond-street. The treatment which the Royal Waterloo Hospital afforded before 1852, the year of the foundation of the Great Ormond-street Hospital, and for many years after that date, was dispensary treatment only. How great was the need of a children's hospital at that time may be gathered from the fact that in January, 1842, out of 2363 persons in all the London hospitals only 26 were children under the age of ten, while of 50,000 person dying annually in the metropolis 21,000 were children under that age.

I am, Sir, yours faithfully,

STEWART JOHNSON, Secretary.

Hospital for Sick Children, Great Ormond-street, London, W.C., June 9th, 1908.

THE MEDICAL DEFENCE UNION.

To the Editor of THE LANCET.

SIR,—At the annual meeting of the Union at Liverpool on May 21st and reported in your issue of the 30th, the chairman is reported as saying—

> It was suggested that some scheme could be adopted by which the whole risk of adverse verdicts and damages should be taken over, but after serious consideration it was decided that it was not possible, and further that it would be against public and professional polity and likely to lead to serious injury to the profession if not to actions for champerty and maintenance.

Now, as one who has been long of opinion that such a scheme is most desirable, could one be devised which was workable, I am naturally disappointed at the result of the deliberations of the Council, but of course find no fault with their decision, which no doubt has been come to for reasons which to them seem sufficient; but what I think many members will not appreciate is how "serious injury to the profession" is likely to result from such a scheme, or how actions for "champerty" and "maintenance" could follow.

I can quite understand that where an insurance company came in as undertaking to indemnify the Union there might be difficulties in arranging as to the conduct of the defence of an action against a member, and I also quite understand how to the company the vindication of the member's professional reputation would weigh as nothing against a prompt and easy settlement by compromise, but surely such a difficulty could be met by the Union itself instituting a scheme of mutual indemnity insurance amongst its members, a much more business-like and dignified mode of making provision against evil fortune than the usual appeal on behalf of the unfortunate one who finds himself at the end of his plaint, whether the result be favourable or unfavourable to him, face to face with very heavy, in some cases ruinous, costs. The machinery seems to me already to exist in the Union's organisation and I do not think it would beat human wit to adapt it to such a further use.

But what about this exposing the member to the charge of "champerty and maintenance"? Not being a member of the sister profession of law I can have no valid opinion of my own, but from anything I can find readily on the subject I fail to see the ground for such an opinion and how such an action could lie.

Champerty is thus defined: "A combination for an evil purpose—a bargain, either with the plaintiff or defendant, to contribute towards the costs of litigation, the price being a share in the spoil"; and the Oxford English Dictionary gives the following:—"*Champerty*, or more correctly *Champarty*: The alleged proceeding whereby a party, not naturally concerned in a suit, engages to help the plaintiff or defendant to prosecute it, on condition that if it be brought to a successful issue, he is to receive a share of the property in dispute" (Vol. II., C.); and "*Maintenance*: The action of wrongfully aiding and abetting litigation; sustentation of a suit or suitor at law by a party who has no interest in the proceedings or who acts from any improper motive," and under the same rubric Sir F. Pollock is thus quoted: "The wrong of maintenance or aiding a party in litigation without either interest in the suit, or lawful cause of kindred, affection or charity for aiding him: is akin to malicious prosecution and other abuses of legal process ..... actions for maintenance are in modern times rare though possible" (Vol. VI., M).

Again, in the Dictionary of English Law, by Charles Sweet, the following occurs: "*Champarty* or *Champerty* is the act of assisting the plaintiff in a legal proceeding, in which the person giving the assistance has no valuable interest, on an agreement that if the proceeding is successful the proceeds shall be divided between the plaintiff and the assisting person"; and "*Maintenance* ..... in the courts includes Champarty and Embracery, and is also used generally to denote the offence committed by a person, who, having no interest in a suit, maintains or supports either party with money or otherwise to prosecute defendant."

Now if the above quotations are to be taken as an at all correct interpretation of the meaning of such acts they might certainly be used as arguments against the intervention of the Union in any suit either undertaken or defended by a member, but I fail to see how they can be used solely as an argument against the Union embarking in any scheme of indemnification of the kind spoken of. If the Union cannot extend its operations in this direction then it seems to me we must try if we can get some of the insurance companies doing this class of business to extend their operations so as to cover medical men just as chemists and dentists are already covered.

I am, Sir, yours faithfully,

June 1st, 1908. A MEMBER.

THE NATIONAL HEALTH SOCIETY.—The Lord Chief Justice presided last week at Grosvenor House over the thirty-fifth annual meeting of the National Health Society. After the presentation of diplomas to a number of the society's successful students by the Dowager Duchess of Westminster, Lord Alverstone commented on the change which had come over public opinion since the society's formation, for in the past year there had been a great demand for trained and qualified women. Medical men had pointed out the hopeless ignorance of many poor mothers as to the feeding and bringing up of young children and he had had extraordinary evidence of this in cases brought before him as a judge. The work of health visitors was therefore greatly needed. He moved: "That the National Health Society is deserving of all support, a more general and thorough knowledge of hygienic principles as applicable to home life being absolutely essential to the welfare of the community." The Archdeacon of London, in seconding, commended the society for constantly revising its publications and so making them reflect the light of fresh medical knowledge. Professor G. Sims Woodhead said that the profession was more and more engaged in "prevention rather than cure," and that before the elements of hygienic knowledge became known to all people had managed to live but they did not live so long. If as much time and money were devoted to prevention as to cure many of our hospitals might be shut and there would be plenty of funds available for those that remained. The motion was supported by Dr. E. B. Forman and Dr. H. R. Kenwood, and was adopted.

NOTES UPON HEALTH RESORTS.

SCANDINAVIAN WINTER HEALTH STATIONS.

(BY A SPECIAL COMMISSIONER.)

V.[1]

THE ANTI-TUBERCULOSIS MOVEMENT IN NORWAY AND PUBLIC SANATORIUMS FOR TUBERCULOUS CASES.

No study of Norwegian health stations can be counted satisfactory and complete which neglects to consider the influence and character of the anti-tuberculosis movement. Norway, in spite of its climatic and other advantages, has suffered much from both leprosy and tuberculosis. The former is now rapidly becoming extinct but the latter has until the last decade been steadily increasing.[2] The fact is, Norwegians have been slow to develop that "health conscience" and "hygienic mind" which are essential to the establishment and maintenance of rational and effective prophylactic measures against tuberculosis. Even still, as your Commissioner had abundant opportunities of noting, there is a conspicuous lack of observance of many of those procedures and precautions which experiment and experience have demonstrated to be essential for the successful conduct of an anti-tuberculosis campaign. Promiscuous spitting is prevalent everywhere. Spittoons are provided in nearly all public places but apparently are never or rarely supplied with disinfectants. Railway carriages generally possess open receptacles for sputum. Spittoons are prominent features in institutions of almost every kind. I was astonished to find a spittoon by the bedside of each patient in the leper hospital near Trondhjem. Scandinavians seem to have an innate propensity for indiscriminate expectoration. This is due no doubt in a measure to the catarrhal conditions induced by overheating of dwellings, excessive smoking, and in some instances chewing of tobacco. The old-fashioned homesteads are almost invariably dark and the arrangements for sleeping are still generally devoid of adequate hygienic requisites. Even in modern houses and public establishments of all kinds the temperature during winter is kept so high as to cause considerable discomfort to an ordinary Englishman.

Open-air methods are clearly not so popular in the Norwegian home as in our own country. Until comparatively recently little has been done to prevent the spread of tuberculous infection and even now the geographical and sociological conditions prevailing in Norway make adequate supervision and the conduct of sanitary reforms matters of considerable difficulty.

ANTI-TUBERCULOSIS MEASURES.

I had the privilege of discussing the anti-tuberculosis movement with Dr. M. Holmboe, the Norwegian State Medical Director at Christiania, Dr. Andvord, Dr. Sömme, and other well-known leaders, and of seeing something of the practical efforts which are now being vigorously carried on with the aim of stamping out this scourge of the people. Norwegian medical practitioners have for long recognised that just as leprosy has been almost exterminated by early recognition and segregation of cases, so tuberculosis will have to be dealt with by the wise application of legislative measures and a personal care of the afflicted patients.

Norway's advanced position in regard to its "tuberculosis laws" is due mainly to the energy and wisdom of its chief medical officers, Dr. M. Holmboe of Christiania and Dr. Klaus Hanssen of Bergen. Norway can justly claim to be the first country in the world to adopt legislative enactments for the compulsory notification of "open" tuberculous cases. Since the beginning of 1901 infectious tuberculous cases have been reported to the district medical officer. If the medical attendant's instructions are not complied with the sanitary authority is empowered to remove the patient to the hospital and necessary disinfection is carried out at the public expense. The salutary effects of legislative measures and educational efforts are now becoming manifest. During the three years 1902 to 1904 the mortality from pulmonary tuberculosis was 2·4 per 1000 inhabitants. In the last ten years the mortality has fallen more than 15 per cent., the most marked decrease being in the urban districts. In Bergen, where the influence of Dr. Klaus Hanssen is far-reaching, it is said that the mortality has decreased 50 per cent. in the course of the last 11 years. The death-rate varies greatly in the different districts or amts as they are called In Kristian amt during the years 1901-05 the mortality varied from 1·6 to 2·0 per 1000, while in Finmarken it was as high as 4·5 per 1000.

In interpreting the foregoing statistics it is necessary to bear in mind the influence of social and national movements. During recent years large numbers of the population have taken to town life and factory work. Agricultural pursuits are on the wane. There are now greater facilities for communication between districts and outlying hamlets are less isolated than formerly. A constant stream of emigration of the vigorous and young is going on to America, the sick and feeble being left behind. Many of those who have become victims of tuberculous disease in the United States and elsewhere are returned to their native land. As Dr. Holmboe has well pointed out, it is necessary not to overestimate or to exaggerate the value of the tuberculosis laws, for all too little time has elapsed to allow of a just estimation.[3]

A special committee of the Association of Norwegian Physicians has been formed, with Dr. Holmboe as chairman, to study the anti-tuberculosis measures in Norway and to direct the various forms of effort and enterprise available for the public good. This committee also seeks to link the campaign in Norway with the international movement which is now exercising world-wide influence.

The Norwegian Women's Sanitary Association, which was originally formed to provide for the injured in time of war and recently has done much to relieve the hard lot of the fisher-folk, has now taken up anti-tuberculosis work and such practical assistance promises to be invaluable. The judicious service of this organisation has in chief measure led to the establishment of "pleiehjems," on the introduction of which Norway may be congratulated. A "pleiehjem" is a nursing-home for advanced consumptive cases. These have been established in various districts of Norway and seem to meet admirably, and at comparatively small cost, the needs of a sparsely populated and far-extending country with limited means of communication.[4] "Pleiehjems" have now been established by eight or ten communes and by some five amts. In Christiania and Bergen special wards are provided for consumptives in the State hospitals. The nursing-homes for consumptives have proved a great boon to the country. They are usually small and homely with, as a rule, only from six to ten beds. A trained nurse acts as superintendent and the medical man of the district serves as medical attendant. The initial cost averages about £50 a bed and the expense of maintenance is comparatively small. These homes were primarily intended for the nursing of "open" and advanced cases of pulmonary tuberculosis likely to be dangerous sources of infection. About 300 beds are now available in these institutions. The "pleiehjem" is certainly a Norwegian institution which might well be adopted by other countries and for certain parts of the British Isles and its colonies should be very suitable. If instead of burying funds in stones and marbles and other needless extravagances some such country homes could be established in this land for cases which the ordinary sanatorium cannot or will not take, a great step would have been taken towards the arrest of tuberculosis among our people.

Norwegian physicians and statesmen, through their experience with leprosy—a disease in many ways akin to tuberculosis—are peculiarly well fitted to approach the practical conduct of the anti-tuberculosis movement without undue pessimism and devoid of extravagant and irrational hopes. Their reasonable legislative measures, rational philanthropic endeavours, and practical methods in dealing with tuberculosis all merit high praise and are worthy of serious study.

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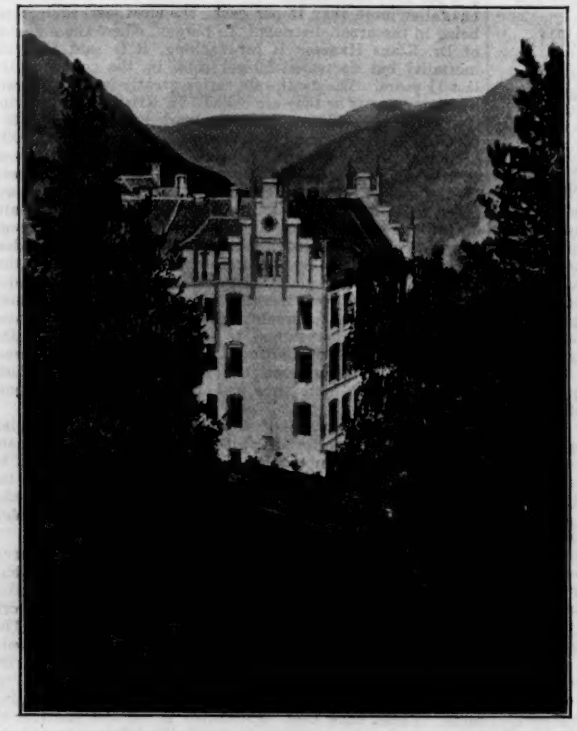
[1] Nos. I., II., III., and IV. were published in THE LANCET of April 25th (p. 1238), May 2nd (p. 1306), 16th (p. 1435), and 30th (p. 1578), 1908, respectively.

[2] J. Sömme: Tuberculosis in Norway and its Sanatoria for Consumption, British Journal of Tuberculosis, October, 1907.

[3] M. Holmboe: "Lungetuberkulosens Cevægelse i Norge, navnlig i de senere aar." Tidsskrift for den Norske Lægeforening, No. 24, Dec. 15th, 1907. Kristiania. Accompanying this article are valuable charts and maps indicating the relative frequency of tuberculosis in the different districts of Norway.

[4] M. Holmboe: "Om Pleiehjem for Tuberkulöse," Kristiania, Alb. Cammermeyers Forlag, 1901.

FIG. 1.



Lyster Sanatorium, showing its elevated position on the mountain side above the Sogne Fjord.

PUBLIC NORWEGIAN SANATORIUMS FOR CONSUMPTIVES.

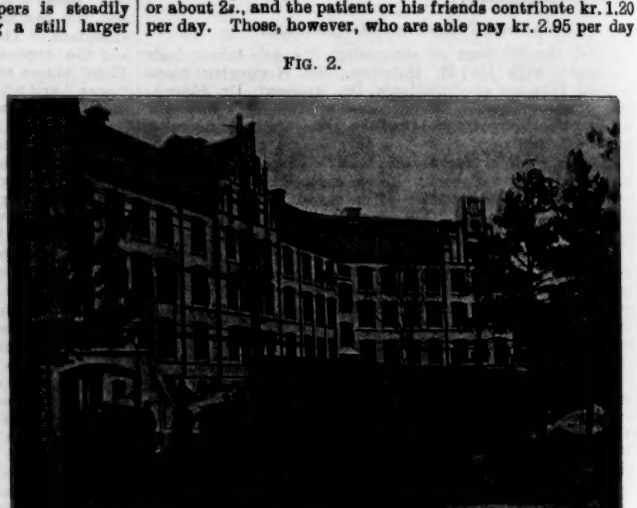
At present Norway possesses all too few public or State institutions for the adequate treatment of early necessitous consumptives. Funds which have been accumulating since the Middle Ages, originally provided for the support and treatment of lepers, are now being devoted to the care of consumptives, and as the number of lepers is steadily declining it seems likely that before long a still larger amount will be available for the establishment of sanatoriums or at all events the control of tuberculous patients. The old leper institution at Reknæs has been converted into an establishment for consumptives and funds originally intended for lepers have helped to build the new sanatorium at Lyster.

Lyster Sanatorium.

This representative institution is thoroughly modern, having been opened as recently as November, 1902. It is situated in the western part of Norway, on the southern slope of the mountain range bordering the Sogne Fjord. In winter it is very difficult of access and one cannot help thinking that it would have been wiser to select a less isolated district. It has been built out of the funds of the ancient St. Jörgen's Leper Hospital of Bergen, and owes its origin to the thought and enterprise of Dr. Klaus Hanssen, the senior physician of the Bergen Hospital. The sanatorium is excellently placed at an altitude of 470 metres above sea level in a peculiarly charming mountainous district (Fig. 1). The climate is sub-Alpine in character. During winter the whole country is snow-clad and frost-bound. At considerable expense a mountain road and wire tramway have been constructed from the lower level to the sanatorium. The institution consists of a main building, four summer houses, an isolation house, stables, and necessary offices and outhouses. Accommodation has been provided for 126 beds and in addition there is room for 12 patients in the summer pavilions. There are 18 bedrooms, originally designed for four patients in each, and allowing about 36 cubic metres per bed. Frequently five cases are placed in each room, the space allowance then being from 29 to 30 cubic metres per patient. There are also three bedrooms for four patients each. Twelve rooms are provided for single cases, but some of these are sufficiently roomy to take two patients. All the bedrooms face south. Separate dining and day rooms are provided for men and women. Good sanitary accommodation is provided for each sex on every storey and in the basement. In the main building are quarters for the medical director, rooms and offices for the resident staff, medical and administrative, and a laboratory. Heating is arranged for by means of a low pressure steam system. Hot and cold water are available throughout. Ample water-supply is provided for lavatories, baths, water-closets, and fire mains. There are modern appliances for steam cooking, electric lighting and ventilation, and an electrically heated disinfector for the sterilisation of sputum. The electrically driven system of ventilation has not been required as free natural ventilation can be secured both during summer and winter by means of open windows. Sewage is dealt with in a septic tank. A plentiful supply of spring water has been brought from the mountains in pipes and is so abundant that it also serves to drive the electric plant which works the tram and provides the lighting. A liegehalle is placed on the south side of the building. The grounds are extensive and adjoin the natural forest region (Fig. 2).

The isolated and elevated situation of the sanatoriums has added much to the initial cost and of course increases the expense of maintenance. The total cost has averaged something like kr. 5960, or about £322 per bed, an expenditure which compared with some similar institutions outside Norway must be considered very reasonable. The total working expenses for each patient are said to be kr. 2.95, or about 3*s.* per day, of which the State contributes kr. 1.75, or about 2*s.*, and the patient or his friends contribute kr. 1.20 per day. Those, however, who are able pay kr. 2.95 per day

FIG. 2.



Lyster Sanatorium. South aspect with open-air shelter.

but of such I understand there are only a few, and they are granted no additional privileges or special consideration. The sanatorium receives no philanthropic support and has no legacies. Possibly in the future additional leper funds may be rendered available for its assistance. I was favoured with copies of the annual reports since 1903, exceedingly well arranged and reflecting great credit on the medical director and his staff. A report embodying the results of the first five years is in preparation. It speaks volumes that of the 1030 patients who have been under treatment all have been followed up except four. At Bergen there exist an after-care committee and a polyclinic on anti-tuberculosis dispensary lines which supervise all cases coming from that town and district. It is well to note that systematised work has for long been very successfully employed as a therapeutic agent on lines very similar to those in use at Frimley and elsewhere in this country. Many patients are employed in the construction of paths of various gradients. During the past five years the male patients have made wide paths for a distance of something like 4·3 kilometres. In the winter snow work and wood-chopping engage much time and attention. The women during the summer assist in the care of the paths and the grounds and engage in gardening. During the winter a number of patients are allowed to walk on skis for one and a half hours after breakfast.

FIG. 3.

View from the grounds adjoining the Fredriksværn Hospital for Tuberculous Children.

Dr. Emil Grundt, the medical director, to whom your Commissioner is indebted for much information, states in regard to this important subject of work for the consumptive that during the last five years about 30 per cent. of his patients have been able to engage in work and without any ill-effects having been noted. The cases are, of course, carefully selected. The temperature taken in the rectum is considered the safest guide. If the temperature after work is raised to 38·2° C. or 38·3°, no notice is taken of it provided that after ten minutes it has fallen to 37·8°. The work of this premier public sanatorium of Norway is so excellent that all Norwegians may well be proud of it and should accord to it all the support which it needs as well as deserves.

Rekvæs Sanatorium.

This institution, situated near Molde on the northern shores of the Molde Fjord, is a converted leper hospital. It consists of a wooden structure of two storeys, with a central portion and two wings, inclosing a courtyard. The wards are small, accommodating from two to four patients in each. Consumptives of both sexes are received and usually a few beds are reserved for children. The difficulty of access to this sanatorium during winter months prevented your Commissioner visiting it.

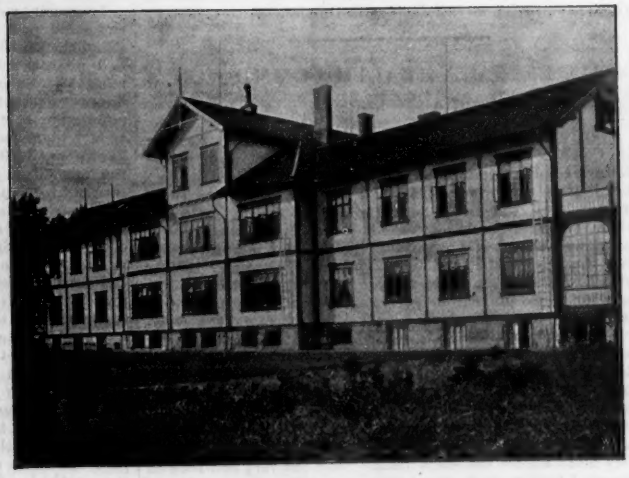
THE CARE OF TUBERCULOUS CHILDREN.

Norway has shown true wisdom in providing for its tuberculous children, and there can be but little doubt that by an extension of means for dealing adequately with tuberculously disposed young subjects lies the best hope for the future. The educational system in Norway is so excellent that there should be but little difficulty in recognising cases in early stages of the disease. By promptly dealing with such, and also by the development of greater domestic hygiene and the separation of children from intimate contact with "open" tuberculous adults, Norway will accomplish much for its "coming race."

The Fredriksværn Hospital for Tuberculous Children.

This is the first seaside sanatorium for tuberculous children established in Norway. It was founded as far back as 1892 by a board, the president of which was the late Queen Sophia, with funds provided by the Royal family, numerous private donors, and the "Samlag" of Christiania. It affords treatment for cases between 4 and 15 years of age. Sufferers from pulmonary tuberculosis are not admitted. The hospital is situated two kilometres distance from Fredriksværn, a picturesque and charmingly situated seaside resort near the mouth of the Christiania Fjord (Fig. 3). Larvik, about three miles distant, which can be reached by either road or boat, is its nearest railway town. The climatic conditions are those of a mild marine station. Experience shows that it possesses no special advantages over a more elevated inland station. Still, the position is convenient of access and its close proximity to the shore offers many attractions for the children. The hospital consists of a wooden main building of two storeys with accommodation for 100 cases, an isolation block, and necessary out-buildings. It also possesses electric and disinfection equipments. The wards are large, well lighted, and airy, and there are commodious day rooms. There are a satisfactory operating theatre and convenient laboratory (Fig. 4).

FIG. 4.



The Fredriksværn Hospital for Tuberculous Children. South aspect overlooking the Christiania Fjord.

The complete cost of the institution amounted to about kr 200 000, or kr. 2000 per bed—that is, a little more than £108 a bed. The working expenses amount to something like kr. 1 50 for each patient per day. The parents or friends of the little sufferers only have to contribute kr. 1.00 a day,

the deficiency being made up by an annual State grant of kr. 15,000 a year.

Up to the present a little more than 1200 cases have been dealt with since the establishment of the hospital. Of these, 27 per cent. have been the subjects of superficial scrofulo-tuberculous lesions, 2 per cent. lupus, 3 per cent. visceral tuberculosis, and 50 per cent. tuberculosis of the bones, joints, and spine.

Dr. Sinding-Larsen, the medical superintendent to whom the institution is indebted for much of its success, took me over the whole establishment and favoured me with full particulars.[5] Treatment is mainly hygienic and dietetic and where necessary resort is made to the resources of orthopædic surgery. Fortunately there is no time limit. If possible patients are kept until they are cured. The average duration of residence is 300 days. Cases of Pott's disease and hip trouble are often retained for upwards of two years. The results appear to have been most encouraging. No less than 83 per cent. are returned as "considerably improved" and "improved." Only 17 per cent. were "not improved" or died. Of the fatal cases 50 per cent. were due to meningitis and miliary tuberculosis. The Fredriksværn Hospital is an institution concerning which Norway may be congratulated.

The Children's Marine Hospital at Hagevik.

A second seaside institution for tuberculous children is situated at Hagevik, which is reached from Bergen. Unfortunately, at the time of my winter visit to Norway the difficulty in reaching this part of the country was so great that a visit to it had to be omitted from my programme. Dr. H. G. Gade, the medical superintendent, has, however, kindly favoured me with copies of his reports,[6] which show that this institution is accomplishing an admirable service for the tuberculous children of Bergen and the western districts of Norway. This institution is now being enlarged and will shortly have accommodation for 100 cases.

Norway has much to show to the many in this and other lands who seem to think that little effective work for the tuberculous can be accomplished without an elaborate and expensive organisation and pretentious, and thus necessarily costly, establishments. Norway, in spite of financial, sociological, and geographical limitations, is accomplishing much towards the stamping out of its most deadly scourge. Other countries should mark and consider the means and measures which are proving so satisfactory in this land of the north.

THE BELFAST HEALTH COMMISSION.

(FROM A CORRESPONDENT.)

IN a recent communication addressed to THE LANCET by Colonel T. Walter Harding, chairman of the recent Belfast Health Commission, he states that when comparing the Belfast death-rate with that of other towns the Commission used the Irish Registrar-General's own estimates when comparing Belfast with other Irish towns, and estimates framed according to the method employed by the English Registrar-General when comparing Belfast with English towns, while for comparing the Belfast death-rate for a given year or period of years with the Belfast death-rate for another year or period of years the Commission made use of its own independent estimate of the population of Belfast. In looking carefully into this part of the report of the Belfast Health Commission it seems that if, to recall the famous dictum of the late Dr. Farr, "vital statistics form the basis of all health reform," they must be based on facts and not on assumptions, and that if comparisons are made as to the vital statistics of different places they must follow the same data. Now the very bed-rock of the vital statistics of any city depends (1) on its population and (2) on the comparison of its death-rate with that of other cities.

1. The population of a city in ordinary parlance is usually given as a certain number "at the last census" but in public health matters the question often arises, What is its population in intercensal years? To quote an example, Belfast was in population 349,180 in 1901 according to the census. What was the number of its inhabitants in 1906? The Belfast Health Commission in its report admits this "is somewhat difficult to determine," and as evidence of this it actually supplies us with four different estimates. (1) The Registrar-General for England, assuming that the population has increased since 1901 in the same ratio that was exhibited during the last intercensal period, would estimate at the middle of 1906 as 397,202. (2) On the other hand, the Irish Registrar-General does not, like his colleagues in Great Britain, estimate the population of communities in Ireland by assuming that the last intercensal ratio of increase or decrease has been maintained. His estimates are framed as the result of consideration of the birth-rate, of the effects of emigration and immigration, and of any local facts of which he can obtain knowledge, and as a result he, in giving evidence at the Commission, calculated the population of Belfast at the middle of 1906 as amounting to 366,220, or 31,000 fewer than an estimate framed according to the British method. (3) The Belfast corporation thinks this official estimate of the Irish Registrar-General is too low and that, as a corollary, the vital statistics based upon it are too high. The chairman of the public health committee estimated the population as being in 1906 388,159, and the city surveyor arrived at a somewhat similar figure as the result of a special inquiry, but in its report the Commission says:—

> In connexion with these estimates, both of which are largely based on the number of "empty" houses in 1906 as compared with the number of houses returned as "uninhabited" in the Census of 1901, it has to be borne in mind that the term "empty houses" and "uninhabited houses" are not synonymous, for the latter term includes business premises unoccupied at night, while the former does not. If allowance could be made for this discrepancy it might well be that both these official estimates would come to be nearly identical with the official estimate of the Registrar-General.

(4) Finally, the Commission, apparently not satisfied with any of the preceding estimates, makes one itself, based upon the number of births registered each year and concludes: "On the whole, therefore, it seems reasonable to assume that the population of Belfast in 1906 was approximately that given in the third column (Table I. showing the population of Belfast, as estimated in different ways, 380,500), namely, in round figures, not much more than 380,000."

Therefore we find the population of Belfast for 1906 is estimated as 366,220 (Irish Registrar-General), 397,202 (English Registrar-General), 388,159 (Belfast corporation), and "not much more than 380,000" (Belfast Health Commission). Such wide discrepancies (397,202 and 366,220) in figures warrant the conclusion that the estimate of the population of a large city like Belfast is, in an intercensal year, a mere speculation. The exact population will not be known until 1911 when it is possible that the estimate of the recognised Irish authority—Sir Robert Matheson—will turn out to be nearest the truth, inasmuch as his calculations are based on far more varied data than those employed in any of the other methods. The importance of having a correct knowledge of the population is shown in Table VIII. in the report of the Commission, where the death-rate of Belfast in 1906, based on populations as estimated (1) by the Registrar-General for Ireland, was 20·1; while (2) by the method of the Registrar-General for England and Wales it was 18·6; and (3) by the number of registered births (the method of the Commission) it was 19·4.

2. How can the death-rate of a city like Belfast be compared with that of other cities in intercensal years? The Commission gets out of this obvious difficulty by using the figures of the Irish Registrar-General when comparing Belfast with other Irish towns, but when it comes to compare the death-rate with that of English towns it employs the method adopted by the English Registrar-General. Table IX. shows the death-rates of Belfast, Cork, and Dublin, based on populations as estimated by the Registrar-General for Ireland, but even in this respect there is doubt, as the Commission says, "such estimates are much less liable to inaccuracy in the case of Dublin and Cork than in the case of Belfast, in view of the less rapid increase of population in these two registration districts." In comparing the death-rate of Belfast with English and Scotch cities the Commission bases the Belfast rates upon populations estimated by the same method as that adopted by the English Registrar-General in order to make them comparable—that is, it makes the population of Belfast 397,202 instead of 366,220 as calculated by the Irish Registrar-General. Now there is great room for doubt in regard

[5] For full details of this interesting establishment and its excellent work reference should be made to the following, prepared by Dr. Chr. M. F. Sinding-Larsen: "Kysthospitalet ved Fredriksværn for Scrofulöse Börn," Kristiania, Steen'ske Bogtrykkerl, 1901;" and "Beitrag zum Studium der Behandlung der Hüftgelenktuberkulose im Kindesalter." Sonderabdruck aus *Nordiskt Medicinskt Arkiv*, 1905 and 1906, Stockholm, Kungl. Boktryckeriet.

[6] Aarsberetning for Kysthospitalet i Hagevik for 1906, Bergen, A. S. John Greigs Bogtrykkeri, 1907.

to this comparison because on page 6 of the report it is stated: "For even if it be conceded that the Irish official estimate is too low there can be very little doubt that an estimate calculated according to the British method is in the particular instance (i.e., Belfast) too high." Further, the return of new buildings erected in Belfast year by year shows that the last intercensal increase has not been maintained since 1901. In 1906, according to the report, the number of new buildings in Belfast fell to 622, which is lower than that for any previous year since 1880. Finally, calculations based on the birth-rate also point to a diminution of the rate of increase of the population. Keeping in mind all these facts, it seems an altogether doubtful, if not fallacious, hypothesis that in comparing the death-rate of Belfast with that of an English city we must first increase the population of Belfast by 31,000 over the number estimated by the accredited Irish authority, the Registrar-General. Such facts render more and more problematical the conclusion of the Commission that "it cannot be maintained that the death-rate of Belfast is, or that it has been in recent years, excessive, as has been alleged, when compared with those of other large cities of the United Kingdom." It is more than likely that in 1911 it will be seen that the estimates now made by Sir Robert Matheson, the Irish Registrar-General, will be nearest the exact facts. The Commission rightly considers it desirable that the whole question of the methods of framing these estimates should be carefully reconsidered by the Registrars-General for the three divisions of the United Kingdom, and that as it is so plainly of advantage to compare the vital statistics of the various communities in these divisions, there should be reasonable uniformity of method in aiming at such estimates. Without some such uniformity it is clear that any useful comparison remains impossible.

THE GERMAN SURGICAL CONGRESS.

(FROM OUR BERLIN CORRESPONDENT.)

(*Continued from p. 1514.*)

Transplantation of Bones.

Professor LEXER (Königsberg) reported the results obtained by him in the transplantation of bones. He said that he had formerly used macerated bones taken from dead bodies and had inserted them under the periosteum where required; small cavities were in this way successfully filled, but in larger ones the inserted bone acted as a foreign body and was generally discharged by suppuration. He accordingly used fresh bone with periosteum which he got from amputated limbs and had in this way obtained excellent results, for the inserted pieces became united. As the presence of the bone marrow was found to produce pyrexia and irritation after the implantation it was previously removed and replaced by a plug containing iodoform which in course of time was absorbed. He gave the history of a series of operations performed by him in this way and explained his procedure. One very remarkable case was that of a man from whom he had removed the upper third of the tibia with the epiphysis, which was then replaced by a part of the tibia of the same size taken from an amputated limb; the knee-joint had comparatively good mobility. In a second case he had replaced an ankylosed knee-joint by an entire knee-joint taken from another person; the operation was successful and the mobility of the new joint was tolerably good. Bones taken from persons suffering from dry gangrene were very suitable for transplantation.

Dr. REHN (Frankfort) mentioned the case of a child whose hip-joint he had resected for coxitis. In order to obtain the formation of new bone he inserted a piece of ivory into the femur in the direction of the acetabulum. A radiogram showed that osseous tissue had developed and a serviceable limb was the result.

The Production of General Anæsthesia by a Combination of Scopolamine and Morphine.

Professor NEUBER (Kiel) expressed regret that the combination of scopolamine and morphine was comparatively little used as a general anæsthetic. In 250 operations which he had performed seven patients had scopolamine and morphine only, whilst in the remaining 243 cases ether was added. It was a great advantage that the patients could be anæsthetised in the ward and put on the operation table in a drowsy condition. The pulse was generally good during the anæsthesia; no excitement, vomiting, salivation, or asphyxia ever occurred. After the operation the patients continued in a drowsy state without feeling pain. Pneumonia was never observed.

A New Method of Producing Local Anæsthesia of the Extremities.

Professor BIER (Berlin) described a new method of producing local anæsthesia. If the limb to be operated on was the arm it was first emptied of blood by an Esmarch's bandage. A soft bandage was then put round it above and below the elbow and an incision was made in the median vein. Any blood which might have remained in the vein was then pressed out and a metallic cannula was inserted through which about 100 cubic centimetres of a solution of novocaine of 0·25 per cent. strength were injected. Analgesia of sufficient duration for the resection of the elbow at once occurred throughout the whole limb. In the lower extremity 150 cubic centimetres of the solution should be injected into the saphenous vein. To avoid the production of toxic symptoms it was essential that the bandage should be loosened by degrees; the analgesia disappeared a few minutes after the bandage was finally removed.

Treatment of Suppuration by the Ferment and Anti-ferment of Leucocytes.

Dr. MÜLLER and Dr. PEISER (Breslau) said that they had endeavoured to convert the "hot" suppuration of acute inflammation into "cold" suppuration by the administration of anti-serum. They used for that purpose either normal blood serum or hydrothorax fluid or ascites fluid containing anti-serum. On irrigation of an abscess with those fluids the purulent discharge became serous within 24 hours, and the granulation of ulcers was accelerated.

Disinfection of the Skin.

Dr. VON BRUNN (Tübingen) said that the skin could be efficiently disinfected by brushing it for five or ten minutes with alcohol of 96 per cent. strength without previously washing in water. He believed that by the astringent effect of alcohol on the skin the germs were fixed. He had found that this method gave just as good results as the complicated process of disinfection devised by Professor Fürbringer.

Dr. HEUSNER (Barmen) recommended for disinfection of the skin a mixture of iodine and benzene by which fatty substances were dissolved in a much higher degree than by ether.

Dr. WEDERHAKE (Düsseldorf) recommended for the same purpose a solution of tetrachloride of carbon of 0·1 per cent. strength which when brushed on the skin for a period varying from three to five minutes reduced the germs by 95 per cent. After the disinfection the skin was covered with "dermagummis," a solution of iodine and caoutchouc in tetrachloride of carbon.

Operations on the Brain.

Professor VON HOCHENEGG (Vienna) showed a patient from whom a tumour of the hypophysis had been successfully removed. He approached the hypophysis by way of the nose and temporarily opened the frontal sinuses which were abnormally large. He then resected the sphenoid bone and scooped out the hypophysis through the base of the sella turcica. The hypophysis was enormously enlarged. A strip of gauze was then passed from the nose through a drainage tube into the cavity and was removed on the eighth day. In three weeks after the operation the patient showed an improvement. The headache disappeared and the power of vision was better. The decline of the symptoms of acromegaly was especially remarkable. The hands became smaller and could now be closed, while the feet became so much smaller that the shoes which the patient had worn before going to the hospital were too large for her at the time of her discharge.

Operation for Graves's Disease.

Professor KOCHER (Berne) recommended an early operation in this disease. In his former series of cases he had had nine deaths among 167 patients, but in his recent series only two deaths among 153 patients. A careful examination of the blood was made in 106 cases, the result being that the red corpuscles were found to have increased to 5 000,000 and upwards per cubic millimetre, whilst the leucocytes decreased from 7000 to 700 per cubic millimetre, the principal reductions being in the polynuclear neutrophiles, whilst the lymphocytes

increased. After the operation the polynuclear leucocytes very soon increased, while the lymphocytes decreased. In the prognosis a decrease in the neutrophile leucocytes and an increase in the lymphocytes were unfavourable conditions. The chance of recovery rose in accordance with the size of the piece of gland which was removed. Professor Kocher had observed that in Graves's disease the coagulability of the blood was impaired.

Operations on the Cervical Glands.

Professor DOLLINGER (Budapest) recommended that in the extirpation of tuberculous cervical glands the incision should be made on the posterior part of the neck, in order that the cicatrix might be covered by the hair and so become less visible than if it was on the front of the neck. He had operated on 200 cases in this way; in 167 of these patients primary union was obtained, whilst in the remainder the discharge ceased within a few weeks. The glands were drawn by forceps into the incision and successively cut away. Cases in which the skin was already thin were, of course, unfit for this method.

(To be continued.)

MANCHESTER.

(FROM OUR OWN CORRESPONDENT.)

Pulmonary Tuberculosis.

AT the last meeting of the Prestwich board of guardians a letter was read from the Grimsby union asking the board to support a resolution in favour of provision by the State of district or county sanatoriums, so that all classes may receive treatment on the latest scientific lines for pulmonary tuberculosis. Some may question the wisdom of looking to the State as the universal provider. But apart from that these cases, the chairman said, had been generally taken over by local authorities. It had never been a question for the State before, "though, of course, if the State would take it over it would be a great relief to the authorities." In the end it was decided to comply with the request. The Stockport guardians on June 4th adopted a resolution to the effect that the time had arrived when the State should provide district or county sanatoriums and that the various boards of guardians should be asked to make a united appeal to the Government to promote legislation on these lines. At a meeting the other day of the Lancaster board of guardians a member said that there was a continual crop of cases of pulmonary tuberculosis at the workhouse and that it was unfair that inmates, especially young people, should be exposed to the risk of infection. It was dangerous, he said, for people to occupy a house where a patient had died from consumption unless it had been thoroughly disinfected, "yet they allowed people in the last stages of phthisis to lie in open wards with people of all ages and conditions of health and unaffected by the disease." If this is so, it certainly points to some want of classification at Lancaster. One of the disheartening experiences connected with hospitals for consumption is, that however much patients may have improved while in hospital, they are not immune against fresh attacks, and after returning to their homes too often appear again at the hospital in a worse state than before. In Manchester the thorough disinfection of the patients' homes, at first disliked by the friends but now welcomed, has certainly been beneficial. It is a good sign that the old fatalistic *laissez faire* ideas are losing their hold.

A Frank Defaulter.

It is not often that the attempts to pass off unsound as sound meat are relieved by a flash of conscious, or perhaps unconscious, humour, but this happened at Preston the other day. A man was fined £5 and costs for exposing the unsound carcass of a pig for sale. He said that he had been bringing pigs to the market for 30 years and would not have brought this if he had known it was wrong. The butcher told him that it was all right. But the chairman told him that he must have known it was not right, and the defendant innocently remarked, "It would have died if I had not stuck it myself."

Adulterated Butter.

The persistent attempts to palm off adulterated butter as genuine seem to show that the game, when successful, is very profitable. From a case that occurred recently where a man was summoned for selling as butter a preparation containing 80 per cent. of margarine, it appears that a considerable organisation is at work to carry on the practice. For the prosecution it was stated that it was not a mere instance of a person keeping a small shop but that they were dealing with a very numerous class. The defendant was ordered to pay a penalty of £20 and costs.

Ignorance as to Anthrax.

A short time ago a farmer at Whitefield was fined £5 and costs for exposing anthrax meat for sale in the Manchester market. He pleaded ignorance and said that he did not know that the cow was suffering from anthrax. The magistrate accepted the plea and imposed a lighter fine than he otherwise would have done. Surely all those who have to do with cattle should know how to detect anthrax.

Bequests.

By the will of Mr. Edward Aston, a Manchester merchant, nearly £40,000 have been left to religious and philanthropic societies, and also to the Northern Counties Hospital for Incurables and to the Manchester Cancer Hospital and Home £1000 each.

June 9th.

NEWCASTLE-UPON-TYNE.

(FROM OUR OWN CORRESPONDENT.)

The Recent Outbreak of Typhus Fever in Gateshead.

Dr. T. M. Clayton, the medical officer of health of Gateshead, gives in his annual report for 1907 some interesting facts relative to an outbreak of typhus fever (happily limited) with which he had to deal between the end of October, 1907, and the end of January, 1908. There were 49 cases in all. From the report it appears that on Oct. 25th Dr. Clayton had his attention drawn to three cases of illness the characters of which aroused a suspicion of typhus fever. Three days later five other similar cases were brought to his notice. In all these cases there was a history of severe illness with fever lasting a fortnight or longer. When seen for the first time there was no rash and the blood failed to react to the agglutination test for enteric fever. The cases were isolated and a diagnosis of typhus fever was made, which was confirmed by the course of the illness in the later cases which were observed from practically the day of onset. The subsequent cases were all traceable to contact with the earlier ones and by far the greater number of them were discovered by the staff of the health department. A nurse was the only person on the special staff employed in connexion with the outbreak who contracted the disease. Dr. Clayton is of opinion that the cases which he saw on Oct. 25th were not the first to occur in the borough. He was led to believe that three deaths certified as due to pneumonia were in reality cases of typhus fever. The first of these deaths occurred on August 31st. Beyond this he has been unable to trace the origin of the disease or the channel through which it gained admittance to the district. 47 cases occurred in 18 houses, with an average of 2·8 rooms and 6·2 inmates per house. Eight cases were removed from one house. The majority of the houses were "dirty, verminous, and ill-ventilated." The density of the population in Gateshead is 38·9 persons per acre. The cases were limited to the north and central parts of the borough. The incidence of cases and population per acre in the several wards affected are as follows:—

Wards.	N.	N.E.	N.W.	E.C.	S.C.	W.C.
Number of cases of typhus fever	1	7	26	12	1	1
Population per acre	91·9	29·4	39·4	166·1	49·5	109·6

All ages were equally affected, the youngest being three weeks and the eldest 51 years. 20 males and 29 females suffered. The deaths numbered four (8 per cent.), two males and two females. In those cases in which it was observed

the rash made its appearance between the fourth and eighth day of the disease; in the majority on the fourth (10 cases) or fifth (14 cases) day. In addition to the ordinary routine methods of isolation, disinfection, &c., special precautions were taken to prevent infection by bites of fleas in infected houses in view of the suggestion that has been put forward that fleas may possibly be carriers of the specific virus. The check on "contacts" was most efficient; only one case was traceable beyond the borough and this was immediately isolated, so that no further harm was done. The success of Dr. Clayton's efforts is very striking; in three months the disease was stamped out entirely. The last outbreak of typhus fever in Gateshead began in 1881 and persisted uninterruptedly until 1889.

Northumberland and Newcastle upon-Tyne Sanatorium.

The sanatorium occupies an isolated position on the rising ground above the North Tyne at Barrasford. The hospital was opened on May 11th, 1907, and between that time and the end of the year 49 patients had been treated, of whom 24 were still in residence on Dec. 31st, the remainder having been discharged. Of the 49 patients, 29 were males and 20 females, the ages varying from 16 to 50 years. Of the 25 discharged, four were not improved, eight had shown some improvement, nine were much improved, and in four the disease was said to be arrested at the time of discharge. Inquiries four months later show that of the 18 males included in the 25 above-mentioned cases, six are at work and four are dead. With regard to cost, the sanatorium authorities state that the average cost per patient during 1907 (seven and a half months only) was £2 19*s.* 11*d.* per week; with 30 patients in residence the cost was about £2 8*s.* It is estimated that with 40 patients the cost will be covered by the fees charged—viz., £2 2*s.* per week; and with the full complement of patients—viz., 50, the cost may possibly come down to £1 15*s.* per patient per week. The sanitary committee of the Newcastle corporation is now proposing to pay the sanatorium authorities £2000 per annum for the use of 20 beds for patients sent by the corporation. The sanatorium had only been open for about seven months at the time when the first report was issued and though possibly it is hardly fair to criticise at such an early stage still, in view of the experience of other places, a stay of 13 weeks in the case of males, or of 16 weeks in the case of females (the average duration of treatment at Barrasford), is quite insufficient in the ordinary way to enable a patient to derive any material benefit. Symptoms may, no doubt, be temporarily relieved and patients be temporarily benefited by a short sojourn of three or four months at a sanatorium but it seems to be now recognised that a very considerably longer period of treatment is essential, even in quite early cases, for any material and lasting benefit to accrue. The recent able and exhaustive report by Dr. H. T. Bulstrode on sanatoriums is a work which would well repay close perusal by those concerned in sanatorium affairs.

Examinations in Medicine, &c.

The secretary of the College of Medicine draws the attention of all candidates intending to present themselves for examination in medicine, surgery, hygiene or public health to the fact that the examinations in Newcastle are now held in March and July instead of as heretofore in April and September. The next examinations will commence on Monday, July 13th next.

June 8th.

THE WINSLEY SANATORIUM.—The health committee of the Bristol city council has under consideration a proposal from the authorities of the Winsley sanatorium. At present patients stay for a period of 16 weeks, but after two months it has been found in many cases that one of two results is obtained—either that there is so little response to treatment that a prolongation of the stay is useless or that the patient has acquired such a knowledge of the treatment that a continuation away from the sanatorium is possible. This being so, it is recommended that in future two months should be the usual period allowed at the institution on the understanding that there shall be provision for a stay of four months if considered advisable. A strong point in favour of the proposition is that it will allow of so many more patients being treated. It is stated that the other public bodies connected with the sanatorium have agreed to the recommendation.

SCOTLAND.

(FROM OUR OWN CORRESPONDENTS.)

Professor of Medicine in the University of Glasgow.

SINCE the death of Sir Thomas McCall Anderson some months ago the chair of Practice of Medicine in the University of Glasgow has been vacant. This week it is announced that the King has been pleased to appoint Dr. Samson Gemmell to the chair. Dr. Gemmell is a graduate of Glasgow, having taken the degree of M.B. in 1872 and of M.D. in 1880. For eight years he discharged the duties of assistant to Sir William Gairdner in connexion with the chair of Practice of Medicine, and he was also clinical assistant to him in the Western Infirmary for a period of four years. In 1887 he was elected physician to the Royal Infirmary and five years later he became physician to the Western Infirmary. In 1880 he was appointed to the chair of Practice of Medicine in Anderson's College Medical School. In 1900 he succeeded Sir Thomas McCall Anderson in the chair of Clinical Medicine. By the appointment of Dr. Gemmell to the chair of Practice of Medicine the chair of Clinical Medicine now becomes vacant.

Scarlet Fever and Milk-supplies.

The medical officer of health of Glasgow has drawn attention to the difficulty which may attend the operation of existing provisions for stopping a milk-supply associated with the occurrence of infectious disease among its consumers. The following case was used to illustrate the difficulty. Attention was directed recently to a milk-supply among the consumers of which certain cases of scarlet fever were occurring. It was ascertained that milk from the same source was being sold at a second dairy in the town and among the consumers here also cases were occurring. The employees of the dairies, as well as of the farm, were examined without any illness which would explain the outbreak being discovered, yet the contemporaneous occurrence of cases on both sections of this milk-supply among persons who had nothing else in common seemed inevitably to suggest the milk-supply as affording the explanation. Viewed in relation to existing legislation some difficulty might arise in a case like this, for while Section 18 of the Glasgow Police (Amendment) Act, 1890, proceeds on the assumption that infectious disease is recognisably present at the source of supply, the Public Health (Scotland) Act, 1897, Section 60, requires "evidence" that disease is being spread in its distribution. It is questionable whether anyone would be justified in maintaining that the foregoing occurrences constitute "evidence" as required by the Act, but they certainly afford reasonable ground for assuming that infection had by some manner not ascertained gained access to the milk before delivery.

Presentation to Dr. Bruce Goff.

The annual dinner of the members of the Glasgow and West of Scotland Branch of the British Medical Association was held last week in the St. Enoch Hotel. The chief feature of the evening was the presentation of a silver Warwick vase and four fruit dishes to Dr. Goff in recognition of the valuable service rendered to the branch, whose representative on the general council he has been for the long period of 25 years.

Meeting of Medical Men on behalf of the Ruchill Medical Officers.

A meeting of the Glasgow and West of Scotland branch of the British Medical Association was held recently in Glasgow to consider the case of the resident physicians who were recently dismissed from Ruchill fever hospital. The meeting, which was very largely attended, expressed its sympathy with the medical officers. It was decided to open a fund to help towards the payment of their legal expenses.

Lady Sanitary Inspector for Port Glasgow.

During the past few years the Port Glasgow town council has several times had under consideration a proposal to appoint a lady sanitary inspector in the burgh, but while sympathising with the suggestion the council could not see its way to incur the expenditure which such an appointment would entail. The matter has, however, now been settled by the generous action of a Port Glasgow lady who has intimated that she is prepared to pay the salary of a lady sanitary inspector for three years. The town council has decided to accept the offer.

Founders' Day at Queen Margaret College, Glasgow.

Last week the lady students and graduates of Queen Margaret College took part in the celebration of Founders' Day. The guests were received by Miss Galloway, LL.D., in the hall of the College. In giving an account of the work done at the College during the past year Miss Galloway referred to the fact that a house had been leased as temporary premises for Queen Margaret Students' Union, as the committee had thought it better not to fix on a site for the permanent building till everything was settled as regards the new class arrangements at the University and Queen Margaret College. The rent and upkeep for this temporary building would be paid from the interest of £8000 already raised for the Union Fund, and thus the capital would be left untouched for the new building. Another important advance made during the year was the purchase of the Queen Margaret Hall of Residence.

Medical Inspection of Greenock Schools.

For some time the question of the medical inspection of schools has been exercising the town council of Greenock. In a Provisional Order which it is at present promoting powers are sought to undertake this work. The school board is resenting this; consequently a meeting has taken place between the committee in charge of the Provisional Order and a deputation of the school board. The latter body alleges that the Education Bill for Scotland placed on school boards the duty of appointing medical inspectors for the schools with the object of having the health of the children properly attended to. If, however, the clause in the Provisional Order were passed there might be conflict between the officials of the corporation and those of the board. It was also pointed out that under the Public Health Act the corporation had already power to enter schools where infectious disease was suspected, and this, it was suggested, was sufficient for the purpose of the local authority. Before coming to any final decision in the matter the Provisional Order committee agreed carefully to consider the views of the school board.

Inverness District Asylum: Appointment of Medical Superintendent.

A meeting of the Inverness district lunacy board was held on June 5th in the county council buildings, Inverness, for the purpose of appointing a medical superintendent for the Inverness district asylum in succession to Dr. R. B. Campbell, who was recently appointed medical superintendent of the Larbert asylum. 23 applications were submitted for the appointment. The final vote took place between Dr. Theodore Charles Mackenzie, senior assistant physician, Royal Asylum, Aberdeen, and Dr. Charles John Shaw, senior assistant physician, Glasgow Royal Asylum. Ten votes were recorded for each of these two candidates and the chairman gave his casting vote in favour of Dr. Mackenzie who was accordingly declared appointed. Dr. Mackenzie, who is 34 years of age, is a graduate of Edinburgh University. He had charge of the male side at Morningside Asylum for three years. In September, 1907, he attended the International Congress on Neurology and Psychiatry at Amsterdam as the delegate of the Aberdeen Medico-Chirurgical Society. He has also visited the asylums in Rome, Naples, Florence, and Reggio Æmilia.

June 9th.

IRELAND.

(FROM OUR OWN CORRESPONDENTS.)

Tuberculosis in Ireland.

A RETURN issued by the Registrar-General shows that during the year 1907 the deaths from all forms of tuberculous disease registered in Ireland numbered 11,677, which is very slightly under the number in 1906, which was 11,756, but it will probably work out at a larger percentage owing to emigration.

Medical Men and the Workmen's Compensation Act.

A case of great interest to the medical profession was tried at the Enniscorthy quarter sessions two weeks ago before county court Judge B. Barry, K.C., in which Mrs. Murphy, widow of the late Mr. D. P. Murphy, L.R.C.P. & S. Irel., medical officer of Killane Dispensary, claimed for compensation for the loss of her husband who was killed in the discharge of his duties. She claimed on behalf of herself and four children between the ages of 10 and 16 years. They were wholly dependent on the earnings of Mr. Murphy, whose salary as medical officer was £120 per annum. On Oct. 15th, 1907, a woman, a maidservant of a farmer in the country, was accidentally shot, and on his way to the scene of the accident Mr. Murphy was thrown from his trap, receiving injuries from which he died on the following day. It was submitted that Mr. Murphy was in the employment of the guardians, who were a corporate body, and that there was a contract of service and that he was a workman within the meaning of the Act. The guardians disputed this view. I give the county court judge's decision in full:—

His Honour: I was going to reserve my judgment in this case, but I don't think I will, because it seems if the intention of the Legislature is not carried out it is the fault of the drafting of the Act of Parliament. From the wording of the Act it is hard to know what was really intended. The proper way to have drawn this subsection was to have defined "workman" as any person and then it would have applied to every person, subject only to the exceptions in Section 9. But the real words that have been followed are "whether by way of manual labour, clerical work or otherwise, and whether the contract is expressed or implied, is oral or in writing." That seems a bit ambiguous. Every contract must be expressed or implied, must be oral or in writing. The drafters of the Act certainly complicated matters very much by inserting, too, "clerical work or otherwise." Because the words manual work or otherwise would restrict the construction of the section to be something which would have the same kind of service as manual labour or clerical work, but what other kind of service is there of the same sort as manual labour or clerical work? I cannot see how you can construct "otherwise" by *ejusdem generis*. There is nothing *ejusdem generis* to clerical work only clerical work, and if I am wrong I will put it in proper order to have it set right. I think the *ejusdem generis* construction, not being applicable, means "otherwise" must get a full and unrestricted meaning, and therefore, subject to what might be said by the Court of Appeal, I will not take the responsibility of throwing out this application. I will reserve this point and conditionally award the sum of £300.

Mr. O'Dempsey, solicitor for the Enniscorthy board of guardians: I ask the Court of Appeal to say whether the deceased was a workman or not within the meaning of the Act. Have you put the general question?

His Honour: Yes. If, in the opinion of the Court of Appeal, the deceased was a workman, I award that the applicant is entitled to the sum of £300—£100 to go to the widow and £200 to be invested for the children in equal shares in the Post Office Savings Bank. The money will be lodged in my name and also Mr. Meadows's

Mr. O'Connor, counsel for applicant: The guardians may not go on with the appeal at all.

His Honour: If they don't prosecute the appeal you will get the order, Mr. O'Connor.

The guardians have appealed and the case will be tried at the Trinity sittings of the law courts in Dublin.

Notes on Sanitary Measures in Ulster Towns.

It is good to find that, thanks largely to the efforts of the Women's National Health Association of Ireland, public health is now getting a due share of attention throughout the country. Recently the Local Government Board of Ireland issued a circular letter on the subject of dairies and cowsheds, pointing out that officers appointed for the inspection of cowsheds and dairy premises should be instructed to make a thorough examination of their respective districts with a view to having all cow-keepers coming under the provisions of the Order registered. The circular also pointed out that as the cattle were now out on grass the requisite structural improvements in the cowsheds should be effected before their return in the autumn. This Order has had a mixed reception, as a rule the urban being more in its favour than the rural councils. The medical officer of health of Lurgan, Dr. Samuel Agnew, in his annual report for 1907, just issued, shows that the general condition of his district has been very satisfactory. With the exception of one death each from scarlet fever and diphtheria, none were due to any of the notifiable infectious diseases. The general death-rate was 19·3 and the zymotic death-rate was 1·4. Special details are given in regard to tuberculous diseases and the greatest hope is expressed that the health association inaugurated by Lady Aberdeen will do much to educate the people in regard to these diseases. Dr. Agnew's report is illustrated by excellent comparative statistical tables. On the advice of Dr. Agnew the people of Lurgan have decided to have their streets more frequently and regularly watered to obviate the danger and nuisance of the dust raised by motors. Omagh urban council had recently before it the question of the sale of methylated spirits for consumption as an alcoholic beverage and it was considered that it should be scheduled as a poison. Mr. Robert Currie, medical officer of health, has drawn the attention of the Ballymena urban council to a large number of insanitary houses in its district, and the Newcastle urban council is arranging to have a report from an engineer on a combined scheme of sewerage, water-supply, and electricity

for that popular seaside summer resort. It is interesting to note that wherever the Tuberculosis Exhibition has gone the Local Government Board has had less trouble in carrying out public health reforms.

Death of Mr. Sidney Brice Smyth, M.A., M.B. Dub.

The medical profession received a real shock when it was announced on Thursday morning last that Dr. Sidney Brice Smyth had died suddenly at his residence, Ulsterville House, Lisburn-road, Belfast. On the evening before he dined with his father (Dr. Brice Smyth), after a hard day's work, without manifesting any signs of illness and retired to rest as usual, but in the morning (June 4th), when his servant went to arouse him, he was found dead from heart failure. For some time past he had been breathless on any great exertion, and at times had presented a cyanosed appearance, and he was arranging to go for a holiday. At the time of his death he was 39 years of age. Dr. Smyth, after being at school at Uppingham, studied at Trinity College, Dublin, where he graduated in medicine in 1890. In the same year he began practice in Belfast and soon, as a result of his energy and ability, established for himself a good position. He was physician to the Belfast Hospital for Sick Children and to the Maternity Hospital, to both of which he rendered valuable services. Dr. Smyth was a keen sportsman, being specially fond of yachting, fishing, and motoring. A personal favourite and a man of most gentlemanly bearing, he was greatly respected by a large *clientèle* of patients who deeply deplore his sudden death. The keenest sympathy is felt with his aged father, a very well-known member of the medical profession in Belfast. Dr. Smyth was unmarried.

The British Dental Association.

The annual conference of the members of the British Dental Association, which now numbers 1675 members, took place during the Whitsuntide holidays in Belfast. On Friday night (June 5th) Mr. L. Matheson, L.D.S., of London, gave a popular lecture, which was very largely attended, on "The Teeth of the People: a National Asset." On Saturday morning, June 6th, in Queen's College, Belfast, after some valedictory remarks from the retiring President, Mr. J. C. Oliver, L.D.S., of Cardiff, the new President, Mr. J. J. Andrew, L.D.S., of Belfast, took the chair and delivered a very practical address in which he referred specially to the importance of the inspection of school children to see the condition of those organs which are most often at fault—the eyes, the ears, and the teeth—and emphasised the fact that the physical condition of children was almost of more importance to a nation than education. In the afternoon Dr. J. Sim Wallace gave an address on "Diet in Infancy and Childhood"; Mr. C. E. Wallis, L.D.S., of King's College Hospital, London, spoke of the necessity of dental clinics; Mr. A. Layton, L.D.S., gave an address on "Experience of Dental Inspection and Treatment in the Kettering Elementary Schools"; while Mr. G. Cunningham, L.D.S., contributed an interesting series of statistics illustrative of his experience of a school dental clinic in Cambridge. The annual dinner took place in the Grand Central Hotel, Belfast, on Saturday evening when the President occupied the chair, and 175 members and guests were present. This entertainment was a marked success. A series of scientific papers were read on Monday and the annual meeting of the Benevolent Fund was held; in the evening the President of the Association and the members of the Irish branch held a reception in the Grand Central Hotel, at which dancing, whist, music, &c., were the features of the evening. One of the most popular exhibits at the meeting was a demonstration given by Professor J. Symington, F.R.S., and Dr. J. C. Rankin showing the development of both the primary and the permanent teeth in young people as illustrated by the x rays method. The radiograms were much admired and Professor Symington was cordially thanked.

June 9th.

PARIS.

(FROM OUR OWN CORRESPONDENT.)

The Etiology of Sydenham's Chorea.

AT the French Society of Oto-Rhino-Laryngology M. de Pontbière has communicated the results of his ten years' observations on the etiology and treatment of chorea. The rapid and permanent cures obtained by removing tonsils which are chronically infected and adenoid vegetations point to the conclusion that chorea is generally the outcome of an auto-intoxication produced by swallowing septic material secreted by the lymphoid organs of the naso-pharynx. This naso-pharyngeal infection is nearly always rheumatic. The pharynx is responsible for the cardiac and articular manifestations of rheumatism which follow on septic or gouty sore-throats. The author adduced the analogy of other local and general symptoms which are common to "adenoid" and to choreic patients, such as deficient nasal respiration, disturbed nights and night-terrors, dyspnœa, tender spots in the side, muscular and intellectual disabilities, difficulty in concentrating the attention (aprosexia), alterations in the character, digestive disturbances and distaste for food, especially in the morning, lymphatism, and the stupid aspect of choreics which is the same as the adenoid facies. The examination of the naso-pharynx is thus of the highest importance in cases of true chorea, as the origin of the neurosis will be often discovered there.

The Employment of Women and Children.

The Minister of Labour has introduced into the Chamber a Government Bill to authorise the public administration to lay down by order the different classes of work dangerous to health or morality which are to be forbidden to women and children under 18 years of age in the establishments coming under the Health and Safety of Workers Act. The object of this measure is to secure to women and children employed in commercial establishments the same protection as is assured to those employed in workshops and factories.

The Wording of Medical Certificates by Practitioners.

The Appeal Court has recently delivered an interesting judgment which puts a certain responsibility upon medical men in drawing up certificates for the detention of insane persons in asylums. It arose from a practitioner adding to such a certificate certain libellous remarks about the patient's neighbours who brought and won an action for damages against him. The defendant took the case to the Court of Appeal which upheld the verdict, holding that a medical man has not an absolute discretion in the wording of certificates, especially when it comes to speaking about third parties whose mental condition is not in question, and that such remarks may be libellous and the proper cause for an action for damages.

Charges against Medical Men.

Two criminal charges against medical men have been occupying the courts recently. The first is concerned with a Dr. B. together with a workman who took service with a master carpenter on August 17th in last year. Three days later he sustained an injury to his thumb in the course of his work which a Dr. J. diagnosed as a sprain; on Sept. 2nd this same medical man certified the patient as cured and fit to resume work. On the strength of this certificate the Common Industrial Fund allowed the man 35 francs temporary indemnity. Three days later, however, he went to consult Dr. B., the defendant in the present case, who treated him until Oct. 10th, when he gave him a certificate dated Oct. 8th to say he was cured, on the strength of which he obtained a further grant of 99 francs from the aforesaid fund. In the meantime, on Sept. 11th, the carpenter had calmly taken a fresh job under a new master, and three days later he stopped work again, pretending that he had injured the same thumb. This time he was looked after by a Dr. A., who on Sept. 23rd signed him up as cured. His second employer paid him 35 fr. 75 c. compensation. On Sept. 27th he went again to Dr. B., who treated him until Oct. 15th, when his second employer paid a fresh compensation of 91 francs. So between Sept. 11th and Oct. 8th he was being paid half wages by two employers, whilst Dr. B. received fees amounting to 70 fr. 50 c. from the employers and the fund. When these facts came to light the man's last employer charged the workman, together with Dr. B., with conspiracy to defraud. The former confessed his double-dealing, but Dr. B. strenuously denied his complicity. The court condemned the workman to pay a fine of 25 francs and to go to prison for six months, and Dr. B. to pay 500 francs, to forfeit his right to practise medicine for five years, and to six months' imprisonment, and further, the two defendants were condemned to pay 500 francs damages to the plaintiffs. In the second case judgment has not yet been delivered, but it concerns a picture-dealer who is also an insurance agent, and who is charged with having conspired with his medical attendant to defraud insurance companies on a large scale. He is alleged to have effected insurances upon the lives

of persons whose health was seriously damaged, often by tuberculosis, and to have substituted healthy persons at the medical examinations for policies.

The Treatment of Keloids by Radium.

At the Academy of Medicine on May 26th M. Wickham and M. Degrais communicated a paper upon the curative effects of radium, in continuance of earlier observations which had convinced them of the favourable effect of radium on epitheliomata of the skin and on vascular nævi. Their new work bears on the treatment of unhealthy scars. They exhibited a number of photographs showing scars, the results of tuberculous lesions, burns, and various injuries, which had disappeared or been greatly diminished in size, and others which showed the specific kind of action which radium exercises over keloids of various forms—for instance, præsternal and spontaneous keloids and those following on acne, anthrax, and scars of wounds. The authors laid stress on the painless and convenient method of application which the treatment permits and which renders it suitable for children of very tender age, and they add that some tumours disappear quietly without the necessity of securing a visible therapeutic reaction. They regard radium as having a selective curative affinity for such affections of the skin as epitheliomata, nævi, and keloids.

The Treatment of Deaf-mutes.

At the same sitting of the Academy of Medicine M. Castex described the training methods employed at the National Institution of Deaf-mutes in Paris. Oral education is relied on to the exclusion of all forms of apparatus, the pupil being trained by slow degrees by the senses of sight and touch to reproduce the movements of the teacher's lips and to emit more or less organised sounds. He gradually learns to read the lips as though they were a written book. The improvement in hearing and vocalisation takes place *pari passu*. As 25 per cent. of deaf-mutes have some trace of hearing M. Castex attempts to cultivate these traces by means of his natural voice. The voice attained by deaf-mutes is as yet monotonous and imperfect and workers in this field are trying to improve its musical quality. M. Castex based his remarks upon the examination of more than 1000 children which he has made during the last ten years.

Laryngotomy for Stenosis of the Larynx.

M. Sieur described this procedure at the Chirurgical Society on June 3rd. He performed laryngotomy on two patients with stenosis of the organ, one case having been caused by typhoid laryngitis and the other by diphtheria. It is necessary to keep the larynx open by fixing the edges of the thyroid wound to the skin. The results have been excellent. M. Broca supported the procedure, which he has also found a useful one, and M. Morestin declared that he would adopt it in future, having completely failed to relieve one of his patients by dilatation.

June 8th.

SWITZERLAND.

(FROM OUR OWN CORRESPONDENT.)

Society for School Hygiene.

THE Swiss Society for School Hygiene, which now has 626 members and 110 associate members, held its ninth annual meeting on May 16th and 17th in the pretty little town of Baden near Zürich, well known for its sulphur springs. The meetings were well attended as a subject of general interest was discussed—namely, forest schools and forest recreation for school children. Dr. Kraft, medical school officer of Zürich, spoke on the medical side of the question, Mr. Hiestand on the educational side, whereas the mayor of Lausanne, M. Schuetzler, illustrated these lectures by narrating the practical experiences which they had already gained at Lausanne, a pioneer town in this new movement in Switzerland. These forest schools are intended for constitutionally weak children whose poor health renders them unfit for the usual school routine. They must be placed near the forests which abound in Switzerland and be fairly easy of access. Class-rooms, rooms for recreation, for rest (*Liegehallen*), rooms for meals, for baths, &c., are to be provided. The classes, which must not exceed 25 children, are to be placed under the continual supervision of the medical officer. The lessons are not to be more than half an hour at a time and altogether two hours per diem. The rest of the day is to be occupied by the simple and wholesome meals, recreation, rest, and baths (simple and saline). Much time can thus be devoted to strengthening the physique, developing the character, and to teaching punctuality, order, &c. The society unanimously adopted a proposition recommending education authorities, teachers, and parents to give every aid possible in instituting such forest schools. The society also resolved to hold a fortnightly course of instruction in the care of the young in September next in Zürich. The mornings are to be reserved for lectures which eminent lecturers, German, Austrian, and Swiss, have been invited to deliver; the afternoons will be devoted to visits at various institutions; in the evenings social meetings or meetings for discussion will take place. Later a similar course is to be held in French Switzerland. Dr. Guillaume, director of the Federal Statistical Bureau in Bern, spoke on the part which ladies should take in sanitary supervision of school children. Dr. Steiger of Lucerne gave a report on the school dental clinique established in that town. The great interest taken in Switzerland in school hygiene is evidenced by the fact that the Annals for 1907 contain 23 articles and lectures on the most varied subjects, including a lengthy report on the conference held in August in London, and that the Annals have now increased to a volume of over 600 pages.

Zürich, May 31st.

VIENNA.

(FROM OUR OWN CORRESPONDENT.)

Optic Neuritis and the Inducement of Premature Labour.

Dr. Meissner at a recent meeting of the Gesellschaft der Aerzte brought up an important subject for discussion. A woman, aged 34 years, was three months advanced in her fifth pregnancy. She had had syphilis six years before and suffered from optic neuritis, which ultimately yielded to a combined iodide and mercury treatment. Two years later she became pregnant for the first time and her sight became very bad but after the birth of a healthy baby it improved, without, however, regaining its former acuity. Since then she had been pregnant three times and always when in this condition her eyes became worse, so that now she applied to the hospital to have premature labour induced in order to save her eyesight. She also complained that during the catamenia her sight generally was worse than at other times. The ophthalmic examination showed distinct signs of optic neuritis, some irregular astigmatism, and also concentric diminution of the field of vision; red was the only colour which she could recognise. The question for consideration was whether there was any connexion between the ocular disturbance and the pregnancy. Was the inducement of premature labour justified because of the possibility of permanent injury to the sight being caused by allowing pregnancy to progress to full term? The supposition that pregnancy alone was responsible for the neuritis must be repudiated, for the presence of syphilis had undoubtedly a great deal to do with it. Nevertheless, the treatment with iodide and mercury, to which the patient had been subjected for four weeks, had not done her any good, and the concentric diminution of the field of vision had increased. But this rather pointed to hysteria, not to an organic lesion. Therefore, in Dr. Meissner's opinion, one was justified in waiting before resorting to the operative measure. In the ensuing discussion it was pointed out by Professor Hochenegg that he had once observed in a pregnant woman an increase in size of the hypophysis cerebri, causing optic neuritis by pressure. This disappeared after the birth of the child, but left always a weakened eyesight. Professor Reuss had seen a similar case in which the patient had given birth to 16 children. She suffered during each pregnancy from bad sight, but the condition remained stationary after that, and when she died, 71 years old, she was not blind. Anyhow, such occurrences are not very frequent, otherwise gynæcologists would have reported them. It was decided in this particular case to wait for further development before complying with the patient's wish that labour should be induced.

Professor Toldt's Resignation.

At the end of this term Professor Toldt, the well-known anatomist, will resign his chair as director of the second anatomical institute in Vienna. He could teach for another two years, being only 68 years old, and 70 being the age limit, but he is overburdened with his scientific work,

especially with anthropological studies, which he is anxious to see finished. He is the author of the well-known anatomical atlas bearing his name, which introduced a new method of illustrating dissected specimens, and of a widely-read text-book. The lectures of Professor Toldt were always well attended, for he had the faculty of inspiring his students with true scientific enthusiasm.

A Threatened Strike in the Bohemian Hospitals.

The medical staffs of all the hospitals in Prague have, with the exception of the consulting physicians, announced their intention of giving simultaneous notice if their grievances are not adjusted speedily, and the professors are helping their juniors by testifying that they cannot do without them. The main points of difference of opinion are the payment and the food, whilst the staff also requests that proper provision should be made for sickness and leave of absence. Here, as in all such affairs, "red tape" is responsible for the conflict, but the profession has decided to make a stand once for all and careful provision has been made to prevent the hospital boards from finding any medical man willing to take over the work if the strike really occurs on July 1st, which date has been fixed as the latest for the adjustment of the questions in dispute. If Prague be successful no doubt Vienna will follow suit, for the controversies here also are only postponed, not adjusted.

The So-called Lion-Man (Hirsuties Congenita Universalis).

Dr. Grosz showed at a meeting of the Medical Society a man who has been the object of much interest to the public and has been "shown" as a "lion-man" in many countries. He is a young Russian, said to be 17 years old, covered over the whole body with fine lanugo hair except on the head where the normal hair is present. The direction of the growth of hair corresponds on the body, especially on the face, with the fœtal growth of hair. In concordance with the hypertrichosis (consisting of fine, yellow-blonde, soft, long silk-like hair) there is a rudimentary development of the alveoli and teeth. Lionel, as the youth is called, has only two teeth, corresponding to incisors, in the lower alveolus; the x rays failed to show the presence of any dental sacs in the alveoli. In dogs showing abnormalities in their hair growth similar disturbances of dentition have been observed. Cases of this kind are very rare; hitherto only 24 have been recorded by Bartels. One of the oldest is the family, described and painted in 1583 by Plater, consisting of father, mother, two boys, and one girl, all of whom were covered with an ample cloak of hair, especially on the face and breast and back. It is remarkable that the majority of the cases belonged to the Slavonic race (Russian Poles). As regards the explanation, Unna's and Siebold's hypothesis is the most likely one: a persisting and continually growing fœtal hair germ, a theory which is supported by the direction of the hair in the case shown.

Septic and Aseptic Hydronephrosis caused by Constricting Blood-vessels.

Dr. Moszkowicz and Dr. Blum recently had an opportunity of showing patients in whom an abnormal course of the renal vessels gave rise to very dangerous symptoms, causing hydronephrosis. In the first case a woman, aged 20 years, suffered every 12 to 14 days from attacks of intense abdominal pain. During such an attack a tumour in the right half of the abdomen could be palpated, but the urine was clear and free from abnormalities. A simple hydronephrosis was diagnosed and in the operation it was observed that the tumour, which was of the size of a large cucumber, consisted of the renal pelvis, whilst the ureter was completely constricted between two taut abnormal vessels about one inch below its upper end. When the vessels were divided the ureter at once was filled with the contents of the sac. An anastomosis between the ureter and the renal pelvis was made in order to facilitate matters. The kidney, which hitherto had not secreted any urine into the bladder (proved by the ingestion of indigo-carmine before operation), resumed its function and the patient made an uneventful recovery. The three cases shown by Dr. Blum were caused by the ureter being constricted by an abnormal renal artery and all three kidneys had become cystic with grave symptoms (colic, polyuria alternating with oliguria, fever, and rigors) pointing to septic infection of the cysts. The patients were girls, aged 20 and 28 years, and a youth, aged 16 years, and diagnosis could be made also by uretero-catheterisation. The coincident occurrence of the cases is rather remarkable, as sometimes years pass without such a case being observed. As regards the prognosis it must be stated to be good, since a careful operation (nephrectomy) is sure to cure the patient, provided the other kidney is sufficiently healthy. Most of the authors are of opinion that two factors must be present to bring about the condition—abnormal blood-vessels and abnormal mobility of the kidney. Then a compression of the ureter may occur with its disastrous results. Functional examination with the modern methods shows whether the remaining parenchyma of the kidney is active enough to be spared or whether the entire organ must be removed.

June 8th.

BUDAPEST.

(FROM OUR OWN CORRESPONDENT.)

The Sixteenth International Congress of Medicine.

THIS Congress will be held at Budapest from August 29th to Sept. 3rd, 1909. The organising committee has already done a great deal to insure the success of the scientific side of the congress and an entertainment programme is well in hand which should insure the social enjoyment of its members. A meeting of this committee was held in May. The scientific publications of the congress will be issued in two parts. The first part, in 21 sections, will contain the prescribed proceedings; the second part, in 22 sections, will contain the discussions and the notified addresses. The formal opening will take place on August 29th. Guests will be invited by the Government and also by the city of Budapest, which will issue to members of the Congress beautifully illustrated and bound souvenir books containing a description of the notable medical institutions of Hungary and views of Budapest and its suburbs.

The Budapest First Aid Society.

On May 10th the twentieth anniversary of the First Aid Society was celebrated. In connexion with this a National First Aid Congress has been held at Budapest, to which congress medical men, teachers, and police officials were invited. There was also a small exhibition arranged by the State railways, at which many modern improvements in railway ambulance cars and motor ambulances were shown. Dr. Geyer, chief police medical officer, delivered an address on the Policeman as Life-Saver.

"Ostanxin," a New Antirachitic Drug.

Dr. Furka has treated a number of rachitic cases with "ostanxin" (calcium paranucleinicum) made by the chemical works of Richter Gedeon of Budapest. Ostanxin is a fine, tasteless powder made from casein by a process of pepsin and hydrochloric acid digestion. It contains 17 per cent. calcium, 9 per cent. nitrogen, and 2½ per cent. phosphorus. As it is easily soluble in water, it can be readily given to children in milk, coffee, and other liquids. Its administration is especially indicated at first for rachitic and scrofulous children, for it helps the development of bones and promotes metabolism, as is proved by the increase of weight after a relatively short time. Dr. Furka has found it a useful tonic for patients convalescent after acute infectious diseases. Children generally take it without dislike, and the records of their weight have shown a noticeable increase in every case. Dr. Furka's cases were admitted into hospital from unhygienic dwellings, and such children enjoying in hospital fresh air and good food would have increased in weight probably without the exhibition of any drug. The drug has been administered in cases of renal hæmorrhage, too, on account of the calcium which it contains. As it was stated that after its administration the albumin excreted in the urine did not increase, whereas in some cases it decidedly decreased, larger doses of the drug have been given to patients. It never did harm to the patients. In some cases the bleeding has abated rapidly under its employment, while in other cases it had no effect at all. In renal complications of scarlet fever Dr. Furka used the drug with benefit. The dose of ostanxin is from one to two grammes three times a day.

The International Society of Medical Abstainers.

This society has issued a circular to Hungarian medical men with the following text:—

The undersigned physicians of every country appeal to every ruler, government, and parliament, and all teachers, clergymen, and others who have at heart the well-being of the present and future generations.

We, who are members of the medical profession and are particularly

able, on ground of our studies, to judge and recognise the effects of alcoholic beverages, consider that it is definitely proved that all alcoholic beverages are entirely superfluous and harmful in a high degree, and that all diseases arising from the consumption of alcohol can and must be exterminated. Before all things we must teach the rising generation and educate it by our own example in abstaining from alcoholic beverages, besides defending them by legislation. We consider this action to be necessary for the health of mankind, and to promote and insure the happiness and well-being of the people.—(Signed) Dr. Holitzer of Pirkenhammer, Dr. Santesson of Stockholm, Dr. Ridge of London, Dr. Laitinen of Helsingfors, Dr. Olrik of Frederikswaerk, Dr. Stein of Budapest, Dr. Vogt of Christiania.

June 8th.

NEW YORK.

(FROM OUR OWN CORRESPONDENT.)

Regulation of Medical Experts.

THE recent discreditable exhibitions of medical expert testimony in the courts of New York have led to a conference of a committee of the Academy of Medicine with a similar committee of the Bar Association for the purpose of devising a system of employment of medical experts which should render their testimony non-partisan and thoroughly trustworthy. The following scheme is proposed. At any time in the pendency of any civil proceeding in any court in which any medical or surgical question is likely to be material, the court or any justice thereof may, or at the request of either party shall, appoint from the list made up as hereinafter provided, one or more persons learned in the science of medicine and surgery, and of not less than seven years' actual practice, as official experts, who shall investigate the facts of the case and give their opinion upon any such question arising in such proceeding, and make written report thereof to the court. The list of names of members of the medical profession, qualified as experts, and recommended to the courts, shall be made by the Academy of Medicine for the courts of New York City and by the Medical Society of the State of New York for the courts in the rural districts. When an expert is summoned in a case by order of the court he shall forthwith make such examination of the case as in his judgment may be necessary and practicable and make written report thereof to the court. Such report shall be open to the inspection of either party and may be read in evidence, and such expert may be called as a witness by either party at the trial. The measure provides that either party at the trial may call other expert witnesses, but at his own expense.

Paresis a Germ Disease.

At the recent annual meeting of the American Medico-Psychological Association Dr. O'Brien, of the Massillon State Hospital, Ohio, made the announcement that at the laboratory of that institution the germ of paresis has been discovered and its effects have been demonstrated. He stated that while in an experimental stage sufficient tests had been made to show that paresis is curable and that he had specific cases to point to as definite results. Dr. O'Brien reported several cases of cure and referred to several asylum superintendents who had used the remedy with favourable results. He began his experiments by taking serum from the spinal canal of living patients and experimenting with it on dogs, rabbits, and rats. The report was received with much incredulity and needs authentic verification.

An Association of Milk Commissions.

A permanent organisation known as the "American Association of Medical Milk Commissions" has been formed. The purpose of the association is to federate and to bring into one compact association the medical milk commissions of the United States; to exchange views and to adopt uniform methods of procedure in the work of securing to communities pure milk; to fix chemical and bacteriological standards; to determine the scope of veterinary inspections; and to foster and to encourage the establishment of medical milk commissions throughout the country. It is believed that once established each milk commission would become a potent factor in the community and would stimulate the efforts of local boards of health and thus eventually raise the quality of the total supply.

Abolition of the Tuberculin Test for Tuberculosis among Cattle.

The enormous destruction of cattle due to the use of the tuberculin test has led to universal protests of farmers against its exclusive use in the diagnosis of tuberculosis in their herds. The result is a radical reform on the part of the Superintendent of Agriculture of New York and some other States in the treatment of cattle. The changed methods will prove of immense importance not only in saving cattle but in protecting the people from the use of diseased milk and meats. The superintendent proposes to apply the usual physical tests in diagnosis and to use tuberculin in doubtful cases only. The remedies employed are to be strictly hygienic and not the slaughter of the affected cattle, except in extreme cases. The affected cattle are to be carefully isolated from the herd, to be properly fed and housed in clean, well-ventilated stables, or pastured on elevated grounds. In general cattle suffering from tuberculosis are to be treated on the same principles as human beings suffering from that disease are treated. Inspectors of herds are to be appointed who are skilled in the diagnosis of tuberculosis in cattle; the farmers are to organise for conference; and stations are to be created where farmers can obtain the advice and aid of the State Inspecting Corps at all times. The new *régime* of dealing with bovine tuberculosis is very popular with farmers and there is satisfactory proof that the sanitation of dairies is to be carried to a high degree of perfection.

The Philippine Islands Medical Association.

This association is composed largely of United States army officers serving in those islands. It recently held its fifth annual meeting in the rooms of the Philippine Medical College at Manila. The sessions were well attended and among the invited guests were the health officer of the British colony of Hong Kong, Dr. Francis W. Clark; Professor Kitajima of the Infectious Disease Institute, Japan; and Dr. Cheng Hao, delegate from His Imperial Chinese Majesty's Government. A large number of interesting papers were read, the subjects being observations, investigations, and experiences relating to the diseases of the islands. The value of this association in a better understanding of the diseases of that country will prove incalculable. One of the papers on the recent epidemics of cholera by Dr. Heiser, director of health for the Philippine Islands, will prove of great service to the local authorities in future efforts to prevent the prevalence of that destructive pestilence. He states that cholera in the provinces always has its origin in Manila; that the cholera organism is continuously present in some form in the sewer system of Manila; that this organism is conveyed, directly or indirectly, from the sewers to easily contaminated articles of food or drink by cockroaches, flies, water-bugs, and other vermin; and that the disease extends from Manila by means of contaminated foods. By thus localising the germ of the epidemic in the sewers he makes plain the remedy to be applied.

The Cause of Milk-sickness or "Trembles."

Much was written about a disease among pioneers in the settlement of this country which was attributed to the milk of cows which were affected by a disease called the "trembles" from one of its most prominent symptoms. When the human subject was seized with this disease it was called "milk-sickness," as it was supposed to be derived from milk from the diseased cow or the meat taken after the animal was slaughtered. The disease seemed to be confined to certain localities as along some rivers and streams. It has never been known east of the Alleghany mountains. Recently it was found to be present in the valley of the Pecos river, New Mexico, over 1000 miles from its previous locality. By the aid of a grant from the Institute for Infectious Diseases, Chicago, Professor Edwin O. Jordan, of the bacteriological department of Chicago University, and his assistant visited the locality for the purpose of investigating the cause of this peculiar disease. They were able to carry on a series of studies which resulted in the discovery of what they regard as the germ and this they have termed "B. lactimorbi." The disease produces degenerative changes in the myocardium, the liver, and kidneys, mostly of a fatty nature.

May 26th.

INDIA.

(FROM OUR OWN CORRESPONDENTS.)

Cholera in Lower Bengal.

THE outbreak of cholera in Lower Bengal has assumed large proportions. Not only has Calcutta been attacked but the Jherria coal fields with their large populations of coolies have been seriously affected. The actual mortality in some

of these places is hardly known, panic having seized many of the miners who fly from one village to another. Many of the collieries have a scanty supply of water and the excessively dry season has dried up the wells. In ordinary circumstances the coolies are well housed and well looked after from a sanitary point of view, but on an occasion such as this the men become scared and leave their sick and dying friends and relatives without hesitation. It is even reported that in those parts where European control is less evident dead bodies have been found lying in dry nullahs and fields left to be devoured by vultures and dogs. In Calcutta the mortality from cholera has been rising rapidly week by week since the Great "Ardhodoya" Festival of Feb. 2nd. In the week ending Feb. 1st there were 24 deaths, in that ending Feb. 8th there were 104 deaths, and the numbers rose gradually until in the week ending April 25th there were 302 deaths. The native quarters, especially the northern part of the city, have been chiefly affected, but several Europeans have been attacked and 11 European deaths have been reported up to date. The prolonged dry weather has been accompanied with an unusually foul state of the river Hooghly and it is to this that the severity of the outbreak must be attributed.

"Epidemic Dropsy."

The outbreak of "epidemic dropsy" which has affected Calcutta for the past eight months seems to be practically over. It has been much more severe than previous outbreaks and many of the cases were quite indistinguishable from beri-beri. Opinion in some quarters has changed with regard to the nature of this disease and there are several who now look upon it as an acute specific contagious disease probably identical with beri-beri. One observer puts the incubation stage at three days. There have been some small isolated outbreaks in other parts of Bengal, but these have been for the most part of a mild character.

Rinderpest in Karachi.

The manner in which the owners of cattle in Karachi, including even the superstitious milkmen, have come forward to secure immunity against rinderpest for their animals may be taken as another hopeful sign that the old objections to inoculation are dying out in the minds of the people. The struggle of medical science in India to overcome the prejudices of the people against inoculation has been a long and a difficult one, but now that a good start has been made with the help of the serum manufactured in Bombay the ravages of the plague should be checked materially.

Health of British Troops in India.

Attention has already been drawn to the highly efficient state of the army in India from a health point of view. When Surgeon-General Sir Thomas J. Gallwey, C.B., K.C.M.G., was specially selected to be principal medical officer of His Majesty's forces serving in India in January, 1902, he initiated what has since been proved to be the most thorough and practical reorganisation of the medical services of the army. His introduction of widespread sanitary improvements in barracks and cantonments has year by year improved the health efficiency of the army. Attention was also directed to enteric fever, malaria, and certain other diseases, each being taken in detail and met with the whole machinery of modern preventive medicine and treatment. Now that the complete statistics for 1907 are available it is satisfactory to observe that the admission-rate to hospital and the death-rate are the lowest on record for India, the former being 855·4 and the latter 8·15 per 1000, as compared with 871 and 10·43 per 1000 respectively in 1906. As regards invalids sent from India to the United Kingdom the figures are still more encouraging. In the trooping season of 1906–07 there were sent under this category to England 2015 sick and 75 insane; during the trooping season of 1907–08 just closed the figures were 1097 sick and 68 insane, or a decrease of 1015, which represents more than the strength of one complete regiment of infantry. There were also 126 fewer women sent home as invalids, and as their husbands have usually to accompany them the net gain to the army for all invaliding out of the country has been over 1100 men. An experiment was tried during the cold weather (trooping season) of sending weakly men to the hills instead of invaliding them to England. The hill stations in India possess an unrivalled climate in the winter months for many kinds of disease, the air being dry and extremely bracing, and the results of employing certain selected hill stations as winter sanatoriums has been on the whole most satisfactory.

Building Regulations for Calcutta.

The building regulations for the city of Calcutta have been the cause of a great deal of trouble for some time past, and two or three attempts have been made to improve them. Unfortunately, and for no definite reason except economy, the post of city architect was abolished last year and the duties have since been placed in the hands of the district engineers. Apart, however, from this retrograde policy the building regulations are very faulty and permit the construction of most undesirable dwellings. The Government has at last appointed a special committee to amend these regulations. It is to be hoped that the post of city architect will be reinstituted, as even if all the district engineers were fitted for this work their time is so occupied with other duties that they cannot properly attend to it.

Death of Lieutenant-Colonel F. S. Peck, I.M.S.

Much regret has been felt in Calcutta and also in Behar at the death of Colonel F. S. Peck, I.M.S. During his leave in England last summer he met with a serious accident, being being knocked down by a train at Sheringham while he was crossing the railway in going the round of the golf links. He had a marvellous escape, as the whole train passed over him, but he sustained severe injuries to the head. He recovered sufficiently to return to India early in November, but his health broke down in Calcutta and he was invalided home last month. Colonel Peck was not only a distinguished surgeon but a keen polo and racquet player and in Behar he was emphatically the right man in the right place.

May 14t .

Obituary.

JOHN JAMES RIDGE, M.D., M.D. (STATE MEDICINE), B.A., B.S., B Sc. LOND, M.R.C.S. ENG., &c.

WE regret to announce the death of Dr. John James Ridge of Carlton House, Enfield, Middlesex. For the last year or two Dr. Ridge had, now and again, seemed to feel the stress of his practice and of the much outside work which he was doing, but hitherto after a short rest and a walking tour in this country or abroad his health and energy have appeared to his outside friends thoroughly to be restored. Some months ago, however, Dr. Ridge asked the council of the British Medical Temperance Association to relieve him of the duties of secretary, and to this request that body felt compelled to accede. At the meeting at which this resignation was accepted Dr. Ridge was nominated a member of council and vice-president of the association. Dr. Ridge was then confined to bed. Afterwards for some time his condition appeared to improve but a sudden change for the worse supervened, and although everything was done that skill and affection could devise the end came on Monday, May 25th.

In Dr. Ridge's strenuous and unselfish life many men have found an example and incentive such as are offered by the lives of few men, even in our profession. Born at Gravesend, of which borough his father was twice mayor, John James Ridge was educated at the City of London School where he took the Tite scholarship at St. Thomas's Hospital. Entering this hospital in 1864 he carried on his studies for his degrees in arts and science and for his medical diploma and degree at the same time. At the age of 19 he graduated B.Sc., in the following year B.A., and in the year following that he obtained the diplomas L.R.C.P. Lond. and M.R.C.S. Eng., and the degrees M.B., B.S., in the University of London, being awarded the University scholarship in surgery, with scholarship and gold medal. In 1869, the year after taking his M.B. degree, Dr. Ridge graduated M.D. and then again in 1891 took the M.D. degree in State Medicine. After holding the appointment of house surgeon at St. Thomas's Hospital Dr. Ridge entered on private practice at Clapham where he made a number of life-long friends. He there commenced that work with which his name will ever be associated, and, with Mr. J. T. Rae, engaged in temperance work amongst the children of the district, working at Grafton-square Congregational Church, in connexion with which a Band of Hope was carried on. The opportunity of taking up the practice of the late Dr. Godfrey soon presented itself and Dr. Ridge left his Clapham practice

and settled down at Enfield where he soon acquired the confidence and affection of a large circle of patients. Later he became medical officer of health of the Enfield urban district council and medical superintendent of the Enfield and Edmonton joint isolation hospital. His reports sent out from this latter hospital hold an important place in statistical literature. One of Dr. Ridge's chief interests, however, was the London Temperance Hospital in Hampstead-road. The first patient was admitted to this hospital on Oct. 6th, 1873, Dr. James Edmunds and Dr. Ridge then constituting the staff. Dr. Ridge was physician to the hospital for 25 years and took a very prominent part in determining the policy and carrying on the organisation and development of the institution, so that when he retired its success was assured. The work of this hospital still continues to increase in importance and its staff in strength.

Dr. Ridge was one of the finest of a fine type, the English practitioner of medicine. A sound and sympathetic physician, a skilled surgeon, a Christian gentleman, keenly interested in the welfare of his fellows, his name will be remembered not merely in Enfield and for his distinctly medical work but throughout the country, nay throughout the civilised world, for his enthusiastic and rational advocacy of the temperance question. Associated with Sir G. Burrows, Dr. James Edmunds, and the late Sir Benjamin Ward Richardson in the formation of the British Medical Temperance Association, Dr. Ridge acted as secretary of that association up to within a very short time of his death. He was ever on the outlook for the best means of advancing its work and one of the last efforts which he made was to organise a number of local centres in order that the interest of the members should be as concentrated as possible.

The *British Medical Temperance Review*, the direct descendant of the *Medical Pioneer*, which he edited, and the *Medical Temperance Journal*, to which he contributed, was his constant care. No trouble was too great if good articles could thereby be obtained and good reports of meetings and trustworthy abstracts of scientific papers offered to the readers of the *Review*. The association and the *Review* have been made models on which similar societies and papers have been founded in foreign countries and in our colonies and Dr. Ridge has been the moving spirit in both. No man in this country was better known or more thoroughly esteemed and admired by medical abstainers abroad than was Dr. Ridge, and it was but fitting that when it came to the election of a president for the New International Medical Temperance Association, founded in Stockholm last July, the choice of the association should fall on Dr. Ridge, a nomination that was carried with acclamation. Although engaged in active practice Dr. Ridge always seemed to be able to find time to take part in any public movement that stirred his imagination or roused his sympathy. Politics, religion, social movements, art, and literature all had their attractions for him; indeed, no one could be with him for even a short time without feeling that every thought and action of the man had its origin in his religion and its direction in his culture. A man of broad sympathies, grand courage, strict integrity, and very human, he gradually but surely gained the confidence and affection of those with whom he came into close touch. A certain shyness and nervousness of manner were sometimes misleading to those who met him but casually. These, however, soon disappeared as acquaintance improved. His strong convictions and his cold logical manner of putting his case naturally made him some enemies, but even those who did not agree with him ultimately came to respect both the man and his convictions.

At the funeral service at Christ Church, Enfield, the note struck throughout was one of triumph. The many friends from all ranks who came to pay their last respects to the "dear doctor" grieved at their loss but rejoiced that they had been privileged to enjoy his friendship.

The following resolution was passed at a meeting of the executive committee of the National Temperance League held on May 28th:—

That the Executive Committee of the National Temperance League have heard with deep regret of the death of Dr. J. J. Ridge, who has been a Vice-President of the League for over 16 years. They desire to place on record their high appreciation of the valuable services which Dr. Ridge has unostentatiously rendered to the temperance cause, first by his active coöperation with the League in its early efforts to influence the medical profession and with the late secretary of the League in his editing of the *Medical Temperance Journal* for 20 years; and secondly by his devoted labours as honorary secretary of the British Medical Temperance Association, of which he was the founder.

PRIOR PURVIS, M.D. LOND., M.R.C.S. ENG., L.S.A.

WE have already recorded the death of Dr. Prior Purvis of Blackheath, the doyen of the University of London, in his ninety-sixth year. In May, 1907, he began to suffer from retention of urine due to an enlarged prostate gland, and as at his age it was not deemed advisable to operate the obstruction gradually increased, requiring the frequent use of the catheter. A fortnight before his death he had severe prostatic hæmorrhage which lasted two or three days, and although this was controlled it left him so enfeebled that he sank and died on May 29th.

Prior Purvis was born at Greenwich on Oct. 31st, 1812. He was educated at "Stockers," at the time a well-known school in Poplar. At the age of 15 years he was apprenticed to Mr. Cornwall, a surgeon in large practice at Fairford, Gloucestershire, and he was very fond of telling tales of those days and how the country labourers would come in crowds in the spring and fall to be "blooded," and how at those times the surgery would resemble a shambles. He was one of those who believed in the change in type of disease, as he was sure that then bleeding did good, whereas now he was equally convinced that it would do nothing but harm. He was also one of those who thought that it was a pity to have given up apprenticeship and used to say that in the old days the medical student learnt his profession before he came to London, but now he enters the hospital entirely ignorant, as a rule, of professional work. In London Purvis studied at the Borough Schools (combined Guy's and St. Thomas's) and in due course took his L.S.A. in 1834 and M.R.C.S.Eng. in 1835; in 1839 he passed the M.B. at the newly established University of London and proceeded to the M.D. in 1842, being amongst the first batch who presented themselves for that degree. He settled in his native town of Greenwich, afterwards removing to Blackheath, and soon obtained a large practice. He took an active part in public works to which he devoted a very considerable portion of his time, being a member of the old vestry, where he was foremost in promoting new projects such as the establishment of the baths and washhouses, under the Baths and Washhouses Act. He was one of the founders of the Mechanics' Institute, delivering some of the earlier lectures himself; he was made acting trustee and treasurer from the first and retained the position until the affairs of the lecture hall, as it was then called, were wound up and the building was sold to the borough council in 1900 to become the Borough Hall. He was also one of the founders and for many years chairman of the Industrial Permanent Benefit Building Society, Greenwich, holding this position at his death; and he was one of the original governors of the Roan School and a Commissioner of Taxes. A Liberal in politics and of a somewhat combative nature he threw himself into all the great political questions of the day, notably that of the admission of the Jews into Parliament. He strongly supported Alderman (afterwards Sir David) Salomons in his Parliamentary candidature and for years was chairman of his Parliamentary committee. The same liberal bent of mind caused him strongly to support the admission of women into the ranks of the medical profession and several of the present medical women have frequently expressed their gratitude to him for his efficient help in their early struggles.

Dr. Purvis took a leading part in the establishment of the West Kent Medico-Chirurgical Society, being its treasurer from its initiation in 1856 till increasing years and infirmity caused him to resign in 1897. On his resignation the members presented him with a very handsome china clock and pair of vases. Two years before his resignation an oration in his honour was instituted, to be delivered annually at the meeting in December by some distinguished member of the profession, to be called the Purvis Oration. Since then the orators have been Mr. Arthur Durham, Dr. John Curnow, Professor G. Sims Woodhead, Dr. A. E. Sansom, Sir Victor Horsley, Dr. Vivian Poore, Dr. J. F. Goodhart, Mr. Anthony A. Bowlby, Dr. J. Rose Bradford, Mr. J. Bland-Sutton, Mr. Jonathan Hutchinson, Mr. A. W. Mayo Robson, and Dr. J. S. Risien Russell. He was also a vice-president of the Medical Defence Union.

Dr. Purvis married in 1840 and celebrated his diamond wedding in 1900; his wife predeceased him, dying in July, 1907. They had ten children, seven of whom survive (two sons and five daughters). The eldest son, John Prior Purvis, has been his partner in the practice for 40 years; his other son, Frank Prior Purvis, is professor of naval

architecture and marine engineering at the University of Tokio, Japan. There are 24 grandchildren and nine great grandchildren surviving. The interment took place at Nunhead Cemetery on June 3rd and was attended by numerous relatives and friends, and representatives from all the various bodies with which he had been connected.

WILLIAM KING BULLMORE, M.D. ST. AND., M.R.C.S. ENG., L.S.A.

Dr. W. K. Bullmore, the eldest son of the late Dr. F. C. Bullmore, died at his residence at Falmouth on June 4th, aged 74 years. Dr. Bullmore received his early education at Falmouth Grammar School and afterwards entered at Middlesex Hospital. In 1857 he became a Member of the Royal College of Surgeons of England and a Licentiate of the Society of Apothecaries. In 1859 he took the M.D. of St. Andrews and afterwards returned to Falmouth where he commenced practice by assisting his father. The deceased, who was a Fellow of the Royal Institute of Public Health and a member of the British Balneological and Climatological Society, had held several public appointments, among them being surgeon in charge of troops at Pendennis Castle and medical officer of health of Falmouth and Truro port sanitary authority. He was surgeon-major in the 1st Cornwall Volunteer Artillery. Dr. Bullmore was a keen sportsman, a yachtsman, and an ornithologist, his collection of Cornish birds being a very fine one. He was the author of "Vertebrata in Cornwall," for which book he received the bronze medal of the Royal Cornwall Polytechnic Society in 1866.

DAVID THOMPSON, L.R.C.P., L.R.C.S. EDIN., L.S.A., J.P.,

CORONER FOR THE COUNTY OF CORNWALL.

Mr. David Thompson died at his residence, "Dunstowe," Launceston, Cornwall, on May 27th, in his seventy-seventh year, from syncope. The deceased, who at one time had a very extensive practice at Launceston, was appointed county coroner 19 years ago. He was also a very enthusiastic Volunteer, having joined in 1859, and at the time of his resignation he was brigade-surgeon-lieutenant-colonel of the Plymouth Brigade. He was a county and borough magistrate. Mr. Thompson was for many years an alderman of Launceston borough council, and on one occasion filled the mayoral chair. He celebrated his golden wedding on Feb. 7th, 1906. Mr. Thompson was most popular in Launceston and was highly esteemed. He leaves a widow and one son and two daughters, with whom much sympathy is felt.

The funeral took place at Launceston on June 5th. It was attended by the mayor, members of the corporation, borough officials, members of the local lodge of Freemasons, and others.

SURGEON-GENERAL SIR JAMES ARTHUR HANBURY, K.C.B., M.B. DUB., F.R.C.S. ENG. & IREL. (HON.), A.M.S. (RETIRED).

THE death occurred at Bournemouth on June 2nd, at the age of 76 years, of Surgeon-General Sir James Arthur Hanbury, K.C.B., who served in the Afghan war of 1878–80 and took part with the expedition into the Bazar Valley, being mentioned in despatches. He also accompanied Sir Frederick Roberts in the march to Candahar and was present at the battle of Candahar. Besides being mentioned in despatches he received the C.B., and the medal with clasp, and bronze decoration. As principal medical officer he served in the Egyptian war of 1882 and was present at the battle of Tel-el-Kebir. Twice mentioned in despatches, he was awarded the K.C.B. and also received the medal with clasp, the Second Class of the Medjidieh, and the Khedive's star. Sir James Hanbury graduated M.B. of Dublin in 1853; he was elected (as a member of 20 years' standing) F.R.C.S. Eng. in 1887 and honorary F.R.C.S. Irel. in 1883. The funeral took place at Bournemouth on June 7th.

DEATHS OF EMINENT FOREIGN MEDICAL MEN.—The deaths of the following eminent foreign medical men are announced:—Dr. William Wright, formerly professor of materia medica in the McGill University, Montreal.—Dr. W. H. Earles, professor of surgery in the Milwaukee Medical College.—Dr. Gigli of Florence, whose name is known in connexion with the operation of hebotomy.

Medical News.

TRINITY COLLEGE, DUBLIN.—At examinations held in Trinity term the following obtained the Diploma in Public Health:—

Part I.—George E. Nesbitt, Thomas O. Graham, Richard G. S. Gregg, and William R. Galwey.
Part II.—George E. Nesbitt, John A. Pringle, William R. Galwey, and Thomas O. Graham.

FOREIGN UNIVERSITY INTELLIGENCE.—*Berlin:* Dr. Eduard Sonnenburg has been promoted to an honorary Professorship of Surgery. Dr. Helbing has been appointed to take charge of the University Policlinic for Orthopædic Surgery. Dr. Max Lewandowsky, *privat docent* of Physiology, has been granted the title of Professor. The title of Professor has been conferred on two private practitioners who are unconnected with the teaching staff of the University, viz.: Dr. Oskar Zeller and Dr. Alexander Czempin.—*Ghent:* Dr. de Nobele and Dr. Gommaerts have been appointed Instructors in the newly established Institute of Physio-therapeutics.—*Göttingen:* The lectures on Pharmacology will be delivered during the present semester by Professor Schwenkenbecher of the Medical Policlinic.—*Kharkoff:* Dr. Penski has been appointed to the chair of Clinical Surgery.—*Lemberg:* Dr. Juraez has been appointed Extraordinary Professor of Laryngology.—*Moscow:* Mdlle. Viera Danchakoffa has been recognised as *privat-docentin* of Histology, being the first lady recognised by any Russian University.—*Munich:* Dr. Ibrahim of Cairo and Heidelberg has been recognised as *privat docent* of Children's Diseases.—*Naples:* Dr. Clemente Romano has been appointed Extraordinary Professor of Orthopædic Surgery.—*Pavia:* Dr. Aldo Cernerri has been recognised as *privat-docent* of External Pathology. Dr. Stefano Lodovico D'Este has been recognised as *privat docent* of Surgery.—*Pisa:* Dr. Amilcare Panella has been recognised as *privat-docent* of Physiology. Dr. Vittorio Grazzi has been appointed Extraordinary Professor of Otology and Laryngology.—*Rio de Janeiro:* Dr. Prowazek and Dr. Giemsa of Hamburg have been engaged by the Brazilian Government for duty at the Hygienic Institute.

THE UNIVERSITY OF LONDON AND KING'S COLLEGE, LONDON.—The Bill transferring to the University of London the powers and duties of King's College, London, "in relation to instruction of a University standard in subjects comprised within the Faculties in the University other than the Faculty of Theology," was considered recently by the Select Committee of the House of Commons on Unopposed Bills. Sir Arthur Rücker, principal of the University of London, and the Rev. Dr. Headlam, principal of King's College, joined the committee in considering the report of the Attorney-General on the Bill, and after some debate it was decided to impose a conscience clause for the protection of students attending King's College. Sir Arthur Rücker having given formal proof of the allegations in the preamble the committee passed the Bill and ordered it to be reported with amendments for third reading.

MOTOR ACCIDENTS IN THE EAST-END OF LONDON.—At the last meeting of the Stepney borough council held on June 3rd the following resolution was ordered to be sent to the Home Secretary and to the Commissioner of Police: "That, owing to the increasing number of accidents caused by motor traffic in the county of London, the maximum speed of all motor and other vehicles should be reduced at most to ten miles an hour, and owing to the serious annoyance and discomfort caused by excessive noise, vibration, &c., the police should be granted enlarged powers to control this class of traffic." The action of the Stepney borough council has no doubt been determined by the unfortunate accident which happened a few days ago when a child, aged three years, was killed in a motor omnibus accident. Eye-witnesses, who included a policeman, stated at the inquest that the child was one of three who attempted to cross the road when the omnibus was about to pass. When they saw the omnibus coming towards them all three ran in different directions. The driver gave ample warning, did all he could to avoid the accident, and succeeded in keeping clear of two of the children, but the third was caught by the front of the vehicle and killed. The omnibus was travelling at a speed of about six to eight miles an hour. The jury returned a verdict of

"Accidental death," exonerating the driver of the omnibus from blame. Local feeling has, however, run so high that a riotous demonstration against motor omnibuses has been made in Mile End-road.

GOLF: CHURCH *v.* MEDICINE.—An interesting match was played at Bristol on June 3rd between local golfers representing the clergy of the Church of England and members of the medical profession. The match resulted in a win for the latter by 8½ points to 4½.

THE summer dinner of the West African Medical Staff will take place on June 22nd next at the New Gaiety Restaurant, Strand, London. Any medical officers who have not yet received an intimation should communicate without delay with Dr. W. T. Prout, 78, Rodney-street, Liverpool.

DONATIONS AND BEQUESTS.—By the will of Mr. F. A. Smith of Ashby-de-la-Zouch the Nottingham General Hospital will receive £1000. Mr. R. H. Wood of Sidmouth and Pantglas bequeathed £1000 to the West of England Eye Infirmary at Exeter for the endowment fund and a like sum to the Devon and Exeter Hospital. Miss E. Henry has given a donation of £1000 to the Northampton Hospital as a memorial to her brother, the late Mr. W. J. Henry.

FRIEDENHEIM HOSPITAL.—The annual meeting of the friends and supporters of the Friedenheim Hospital (Home of Peace for the Dying) will take place to-day (Saturday) at 3.15 P.M., in the Hampstead Conservatoire, Swiss Cottage, N.W. Princess Louise Augusta of Schleswig-Holstein will preside and will be supported, among others, by the Duchess of Somerset, Mr. John Langton (chairman), the Rev. Prebendary Webb-Peploe, Mr. A. Pearce Gould, Dr. P. J. F. Lush, Dr. A. T. Schofield, and the Rev. H. Summerhayes.

WORTHING HOSPITAL.—A bazaar has just been held at Worthing in connexion with the local hospital extension scheme. Constant enlargement has been necessary to cope with the work which has fallen to its lot. About 200 in-patients and 2500 out-patients, in addition to many minor cases, are received annually. The work of raising the sum required—from £1600 to £2000—has been a special effort of the mayor, Alderman F. C. Linfield. On one day the bazaar was opened by His Highness the Jam Saheb of Navanagar, who gave the mayor a cheque for 20 guineas.

LITERARY INTELLIGENCE.—His Majesty the King, who has always shown a keen interest in the housing conditions of the people and who in 1884 and 1885 as Prince of Wales sat on a Royal Commission to inquire into the housing conditions of the working classes, under the presidency of Sir Charles Dilke, has accepted a copy of Mr. J. S. Nettlefold's book on "Practical Housing," published by the Garden City Press at Letchworth. The book explains the methods of site planning co-partnership tenants societies and a second edition of it is being prepared.

NEW WATER-SUPPLIES.—The new water-supply for Totnes (Devon) was formally inaugurated on May 28th in the presence of a large gathering. The new supply has been granted to the town by Mr. S. Cary for 99 years, at a nominal rent, and the local authorities are entitled to take from May to November 20,000 gallons daily, which will gravitate to the highest point in the town and can be stored in any of the reservoirs.—A Local Government Board inquiry was held at Stoke St. Gregory, near Taunton, on May 20th, into the application of the Taunton rural district council for permission to borrow £3000 for the purpose of securing a water-supply for Stoke St. Gregory, Hatch Beauchamp, and North Curry.

PHARMACEUTICAL SOCIETY OF GREAT BRITAIN.—At a meeting of the council of this society held in London on June 3rd Mr. J. Rymer Young of Warrington was re-elected president, it being the unanimous wish of the members of the council that Mr. Young should retain his position in view of the society's attitude regarding the proposals of the Government to amend the law relating to the sale of poisons now before Parliament. Mr. J. F. Harrington was re-elected vice-president, and Mr. Walter Hills treasurer. The bronze medals for the elementary course in botany, practical chemistry, and materia medica have been awarded to Miss Grace M. Neve.—The distribution of prizes at the School of Pharmacy will take place on Wednesday afternoon, June 24th, at 3 o'clock, at 17, Bloomsbury-square, London, W.C.

Parliamentary Intelligence.

NOTES ON CURRENT TOPICS.

The Whitsuntide Holidays.

THE House of Commons has taken a very short Whitsuntide holiday this year. The adjournment took place on Thursday, June 4th, and the House reassembled on Wednesday, June 10th. Only three Parliamentary days were included in the holiday. As the House had a long holiday at Easter in consequence of the rearrangement of Ministerial offices and as much of the Government business is by no means well advanced it was felt by the PRIME MINISTER and his colleagues that only a short space of time could be devoted to the Whitsun recess this year by the Commons. The House of Lords, however, has taken a fortnight's holiday. It is understood that the Government is aiming at concluding the summer session of Parliament about July 20th and at calling Parliament together for an autumn session in October.

The Progress of Legislation.

It is the fate of most Bills introduced by private Members to remain on the notice paper awaiting second reading until the end of the session and then automatically to be extinguished. The House of Commons has not the time to examine and to deal with all the 250 Bills introduced in the course of a session and very few are permitted to pass through their various stages without discussion. There is one Bill of interest to the medical profession—the Prohibition of Medical Practice by Companies Bill—which has had the misfortune to remain unconsidered up to the present, although it was introduced in the early part of the session. It has the approval of the General Medical Council. It is in the charge of Sir JOHN TUKE whose position as Member for the Universities of Edinburgh and St. Andrews gives him considerable weight in matters affecting the learned professions. It is supported by members on both sides of the House. It was fully considered by a committee of the House of Lords last year and it passed through all its stages in that chamber. Yet when an attempt has been made to get a second reading for it at the time of unopposed business objection has been invariably taken to it. Its progress has thus been effectually blocked. Amongst other Bills which are still awaiting second reading are: the Coroners' Inquests (Railway Fatalities) Bill, the Coroners (Ireland) Bill, Lord ROBERT CECIL'S Infant Life Protection Bill, Mr. HAY'S Nurses Registration Bill, Mr. MUNRO FERGUSON'S Nurses Registration Bill, the Parochial Medical Officers (Scotland) Bill, the Public Health Officers Bill, and the Purity of Milk Supplies (Scotland) Bill. Mr. HIGHAM'S Coroners' Inquests Bill has passed through a standing committee. Bills introduced by members of the Government have special facilities for advancement. The Children Bill, which deals amongst other matters with infant life protection and juvenile smoking, has made good progress in standing committee under the care of Mr. HERBERT SAMUEL, the Under Secretary for the Home Department. Mr. BURNS'S Housing, Town Planning, &c., Bill has also been sent to a standing committee.

Tuberculosis Prevention (Ireland) Bill.

Mr. BIRRELL has at length introduced his Tuberculosis Prevention (Ireland) Bill into the House of Commons. It is designed "to prevent the spread and provide for the treatment of tuberculosis and for other purposes connected therewith." Mr. BIRRELL has the special support of Mr. CHERRY, the Attorney-General for Ireland, in bringing forward the Bill, which has, as a matter of form, been read a first time.

Experiments on Living Animals.

On the motion of Mr. HERBERT SAMUEL a return has been ordered by the House of Commons to show the number of experiments on living animals carried out under licences in the year 1907.

HOUSE OF COMMONS.

WEDNESDAY, JUNE 3RD.

Medical Referees.

Sir CHARLES DILKE asked the Secretary of State for the Home Department whether his attention had been called to the apparent inconsistency of surgeons appointed by the Home Office to official positions as, for example, those of medical referee or certifying surgeon, holding at the same time positions in which they had to represent an interest sometimes at variance with their official functions; whether in consequence the same surgeon often had to act judicially and also to be called as a witness by a litigant in the same case; whether the certifying surgeons in the Potteries districts held appointments from the Potteries Insurance Company; whether such certifying surgeons investigated on behalf of the insurance company cases of suspected lead poisoning first diagnosed by the medical attendant of the workmen and attended the directors' meeting to be consulted by the insurance company upon cases in their respective districts; whether a workman could only receive compensation for disablement from a scheduled disease if he first obtained a certificate, while in the event of appeal against refusal of a certificate the certifying surgeon was often retained by the insurance company or employers to represent them in appeal; whether he would consider the possibility of providing in future appointments for a greater separation of duties; and in the case of lead poisoning whether he would allow the matter to be considered by the departmental committee.—Mr. GLADSTONE furnished the following written reply: In the case of medical referees under the Workmen's Compensation Act it is, with few exceptions, made a condition of appointment that the referee shall not hold any position

such as that of a works doctor or medical officer of a workmen's club or any regular employment from an accident insurance company, which might cause him to be regarded as representing the interests of any party in cases arising under the Act. The case of certifying surgeons who are primarily appointed for duties under the Factory Act stands on a somewhat different footing and no similar condition is imposed. I have made inquiries, however, of the certifying surgeons in the Potteries district and am informed by them that they do not hold appointments from the Potteries Insurance Company and do not investigate on behalf of the company cases of suspected lead poisoning or attend the directors' meetings. It appears that in pursuance of an arrangement made before the passing of the Workmen's Compensation Act, 1906, in connexion with the scheme of insurance in the special rules the certifying surgeons have made weekly examinations of operators who had been suspended by them under the rules and furnished the worker with a certificate of his condition. There have been very few appeals so far against the determination of certifying surgeons—in the first nine months ten, of which two only referred to lead cases—and I cannot say whether the certifying surgeon has appeared before the referee or not. The certificate of the surgeon which is appealed against has, under the Secretary of State's rules, to be submitted to the referee, who is also required to consider any statements made or submitted by either party. If either party wishes to submit any explanation by the certifying surgeon of the grounds for his decision I do not think that could properly be prevented. As regards the point raised by my right hon. friend in the penultimate sentence of the question, this is already provided for, as above stated, in the case of medical referees, and as regards certifying surgeons it has not escaped my consideration. It would not, however, be possible to lay down a strict rule because in industrial districts it is often difficult to find a well-qualified medical man who does not hold some appointment from employers or associations of workpeople. The question would be outside the scope of the reference to the Lead Committee, but I shall be happy to inquire into any case of grievance which may have come to the notice of my right hon. friend.

The Public Health (Regulations as to Food) Act.

Mr. MORTON asked the President of the Local Government Board to state when it was proposed to issue the regulations under the Public Health (Regulations as to Food) Act.—Mr. BURNS: I hope shortly.

THURSDAY, JUNE 4TH.

The Regulation of the Milk-supply.

Mr. SNOWDEN asked the President of the Local Government Board whether he was yet in a position to say when he hoped to introduce the promised Bill for the better regulation of the milk-supply.—Mr. BURNS replied: I cannot at present fix a date for this purpose.

Mr. WATT also asked the Secretary for Scotland whether the Bill dealing with milk, which was to be introduced for England and Wales by the Government, would apply to Scotland.—Mr. SINCLAIR said: The answer is in the negative. I may add that legislation for Scotland, which is under separate administration, is under consideration.

The Inebriates Acts in Scotland.

Mr. WATT asked the Secretary for Scotland whether it was his intention to appoint a Scottish Commission to inquire into the working in Scotland of the Inebriates Acts; and, if so, when he would make the appointments.—Mr. SINCLAIR replied: The matter is engaging my close attention and I hope to be able to make an announcement at an early date.

BOOKS, ETC., RECEIVED.

BAILLIÈRE, TINDALL, AND COX, 8, Henrietta-street, Covent Garden, London, W.C.

A Manual of Diseases of the Eye. By Charles H. May, M.D., New York, Chief of the Eye Clinic, Columbia University, New York, 1890–1903; Ophthalmic Surgeon to the City Hospitals, the French Hospital, the Red Cross Hospital, and the Mount Sinai Hospital, New York; and Claud Worth, F.R.C.S. Eng., Consulting Ophthalmic Surgeon to the West Ham and East London Hospital, Assistant Surgeon to the Royal London Ophthalmic Hospital, Moorfields. Second edition. Price 10*s.* 6*d.* net.

Physical Signs of Diseases of the Thorax and Abdomen. By James K. H. Sawyer, M.A., M.D. Oxon., M.R.C.P. Lond., Casualty Assistant Physician and Medical Registrar, the General Hospital, and Physician to Out-patients, the Children's Hospital, Birmingham. Price 5*s.* net.

The Treatment of Gonorrhœa in the Male. By Charles Leedham-Green, M.B., F.R.C.S., Surgeon to the Queen's Hospital, Birmingham, Surgeon to the Birmingham and Midland Hospital for Children, Consulting Surgeon to the Birmingham General Dispensary. Second edition. Price 5*s.* net.

BUTTERWORTH AND CO., 11 and 12, Bell Yard, Temple Bar, London.

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Clinical Methods. A Guide to the Practical Study of Medicine. By Robert Hutchison, M.D., F.R.C.P., Physician to the London Hospital, and Assistant Physician to the Hospital for Sick Children, Great Ormond-street; and Harry Rainy, M.D., F.R.C.P. Ed., F.R.S.E., Assistant Physician to the Royal Infirmary, Edinburgh. Fourth edition, thoroughly revised. Price 10*s.* 6*d.*

CHEMIST AND DRUGGIST, THE, Offices of, 42, Cannon-street, London, E.C.

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Uric Acid as a Factor in the Causation of Disease. By Alexander Haig, M.A., M.D. Oxon., F.R.C.P., Physician to the Metropolitan Hospital and the Royal Hospital for Children and Women; late Casualty Physician to St. Bartholomew's Hospital. Seventh edition. Price 14*s.* net.

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Medizinisches Literatur und Schriftsteller-Vademecum, 1907–08. Herausgeber: H. Albert, Bibliograph. Price not stated.

FROWDE, HENRY, AND HODDER AND STOUGHTON, Warwick-square, London, E.C.

Oxford Medical Publications. The Operations of General Practice. By Edred M. Corner, M.A., M.C., M.B. Cantab., B.Sc., F.R.C.S., Surgeon in Charge of Out-patients at St. Thomas's Hospital and to the Children's Hospital, Great Ormond-street; Consulting Surgeon to the Wood Green and Purley Hospitals; formerly Erasmus Wilson Lecturer to the Royal College of Surgeons; and H. Irving Pinches, M.A., M.B., B.C. Cantab., M.R.C.S., L.R.C.P., Clinical Assistant to the Children's Hospital, Great Ormond-street, late House Surgeon and Obstetric House Physician to St. Thomas's Hospital. Second edition, revised and enlarged. Price 15*s.* net.

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KING, P. S., AND SON, Orchard House, Westminster.

National Conference on Infantile Mortality. Report of the Proceedings of the National Conference on Infantile Mortality, held in the Caxton Hall, Westminster, on March 23rd, 24th, and 25th, 1908. President, Right Hon. John Burns, M.P., President of the Local Government Board. Price 1*s.* 6*d.* net.

LEWIS, H. K., 136, Gower-street, London, W.C.

Experimental Researches on Specific Therapeutics. By Prof. Paul Ehrlich, M.D., D.Sc. Oxon., Director of the Königliches Institut für Experimentelle Therapie, Frankfort. The Harben Lectures for 1907 of The Royal Institute of Public Health. Price 2*s.* 6*d.* net.

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Handbook of Medicine and Therapeutics. By Alexander Wheeler, L.R.C.P. & S.E., and William R. Jack, B.Sc., M.D., F.F.P.S.G., Assistant to the Professor of Practice of Medicine, Glasgow University; Assistant Physician to the Western Infirmary of Glasgow. Third edition. Price 8*s.* net.

LONGMANS, GREEN, AND CO., 39, Paternoster-row, London, E.C. (CHARITY ORGANISATION SOCIETY, Denison House, Vauxhall Bridge-road, London, S.W.)

The Annual Charities Register and Digest. Seventeenth edition. By C. S. Loch, Secretary to the Council of the Charity Organisation Society, London. Price 5*s.* net.

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OLIPHANT, ANDERSON, AND FERRIER, Edinburgh and London.

The Origin and Nature of Man. By S. B. G. McKinney, M.A., L.R.C.P. Edin. Parts II. and III., Evolution. Price 1*s.* net.

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Electric Ions and their Use in Medicine. By Professor Stephane Leduc, Professeur at the School of Medicine at Nantes. Translated by R. W. Mackenna, M.A., M.B., Ch.B. Edin., Physician to the Liverpool Skin Hospital. With an Appendix by the Translator. Only Authorised Translation from the French Edition. Price 2*s.* 6*d.* net.

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STEINHEIL, G., 2, Rue Casimir-Delavigne, Paris.

Leçons de Clinique Obstétricale. Par le Dr. Queirel, Professeur de Clinique Obstétricale à l'École de Médecine et de Pharmacie de Marseille, Membre Correspondant de l'Académie de Médecine. Troisième Série. Price Fr.6.

TIP. EDITRICE S. BERNARDINO, Siena.

Di una Forma di Splenoadenopatia Cronica dovuta ad un Bacillo Sottile. Studio clinico, batteriologico e sperimentale del Dott. Guido Ferrarini, Aiuto e libero docente. Price not stated.

TREAT, E. B., AND CO., 241–243, West 23rd-street, New York.

Transactions of the American Pediatric Society. Nineteenth Session held at the Arlington Hotel, Washington, D.C., on May 7th, 8th, and 9th, 1907. Edited by Linnæus Edford La Fétra, M.D. Volume XIX. Reprinted from Archives of Pediatrics, 1907–1908. Price not stated.

Appointments.

Successful applicants for Vacancies, Secretaries of Public Institutions, and others possessing information suitable for this column, are invited to forward to THE LANCET *Office, directed to the Sub-Editor, not later than 9 o'clock on the Thursday morning of each week, such information for gratuitous publication.*

CAIRD, FRANCIS MITCHELL, M.B., C.M. Edin., F.R.C.S. Edin., has been appointed Regius Professor of Clinical Surgery in the University of Edinburgh.

DENNIS, A., L.D.S., L.R.C.P. Lond., M.R.C.S., has been appointed House Surgeon at the Royal Dental Hospital of London.

FLETCHER, E. E., L.D.S., has been appointed to the Appliance Department of the Royal Dental Hospital of London.

GEMMELL, SAMSON, M.D., C.M. Glasg., F.F.P.S. Glasg., has been appointed Professor of the Practice of Medicine in the University of Glasgow.

HARWOOD, L. A., L.D.S., has been appointed House Surgeon at the Royal Dental Hospital of London.

MACKENZIE, THEODORE CHARLES, M.B., F.R.C.P. Edin., has been appointed Medical Superintendent of the Inverness District Asylum.

MURPHY, EDWARD ERNEST ALBERT, L.R.C.P. & S. Edin., L.F.P.S. Glasg., has been appointed Assistant Medical Officer at the Devon County Asylum, Exeter.

OVEY, W. C., L.D.S., has been appointed House Surgeon at the Royal Dental Hospital of London.

SKERRETT, FRANK B., M.B. Lond., D.P.H., has been appointed School Medical Inspector for the County Borough of West Ham.

SMYTH, F. R., L.D.S., has been appointed House Surgeon at the Royal Dental Hospital of London.

VON BERGEN, C. W., M.B., B.S. Durh., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Leatherhead District of the county of Surrey.

Vacancies.

For further information regarding each vacancy reference should be made to the advertisement (see Index).

ARGENTINA, BRITISH HOSPITAL, Buenos Aires.—Assistant Resident Medical Officer, unmarried. Salary £200, increasing to £300 per annum, with board and lodging.

AYLESBURY, BUCKS COUNTY LUNATIC ASYLUM, Stone.—Senior Assistant Medical Officer. Salary £175 per annum, with board and apartments.

AYLESBURY, ROYAL BUCKINGHAMSHIRE HOSPITAL.—House Surgeon, unmarried. Salary £100 per annum, with board, lodging, and washing.

BANGOR, CARNARVONSHIRE AND ANGLESEY INFIRMARY.—House Surgeon. Salary £100 per annum, with board, washing, and lodging.

BATH, ROYAL MINERAL WATER HOSPITAL.—Resident Medical Officer. Salary £100 per annum, with lodging, board, and laundry.

BIRMINGHAM GENERAL DISPENSARY.—Resident Locum. Salary £4 4*s.* per week, with apartments.

BRIDGWATER HOSPITAL.—House Surgeon, for six months. Salary at rate of £80 per annum, with board, lodging, and washing.

BRIGHTON, ROYAL ALEXANDRA HOSPITAL FOR SICK CHILDREN, Dyke-road.—House Surgeon. Salary £80 per annum, with board, lodging, and washing.

BRIGHTON, SUSSEX COUNTY HOSPITAL.—Third House Surgeon, unmarried. Salary £50 per annum, with board and residence.

BRIGHTON THROAT AND EAR HOSPITAL, Church-street, Queen's-road.—Non-resident House Surgeon for six months, renewable. Salary at rate of £100 per annum.

BRISTOL ROYAL HOSPITAL FOR SICK CHILDREN AND WOMEN.—Assistant House Surgeon for six months. Salary £50 per annum, with board, rooms, and attendance.

BURY ST. EDMUNDS, WEST SUSSEX GENERAL HOSPITAL.—House Surgeon, unmarried. Salary £100 per annum, with board and lodging.

CARMARTHENSHIRE INFIRMARY.—Resident Medical Officer, unmarried. Salary £100 per annum, with apartments, board, attendance &c.

CITY OF LONDON HOSPITAL FOR DISEASES OF THE CHEST, Victoria Park, E.—House Physician for six months. Salary at rate of £50 per annum, with board, residence, and washing.

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DERBY, DERBYSHIRE ROYAL INFIRMARY.—Assistant House Surgeon for six months. Salary at rate of £60 per annum, with board, residence, and washing.

DUMFRIES AND GALLOWAY ROYAL INFIRMARY.—Assistant House Surgeon. Salary £35 per annum, with board and lodging.

ENFIELD AND EDMONTON ISOLATION HOSPITAL, World's End, Winchmore Hill.—Resident Assistant Medical Officer. Salary £150 per annum, with rooms, rations, and washing.

EVELINA HOSPITAL FOR SICK CHILDREN, Southwark Bridge-road, London, S.E.—Eight Clinical Assistants in the Out-patient Department. Also Honorary Anæsthetist.

FARRINGDON GENERAL DISPENSARY AND LYING-IN CHARITY, 17, Bartlett's-buildings, Holborn Circus, E.C.—Resident Medical Officer. Salary £100 per annum, with rooms, attendance, fire, &c.

KING EDWARD VII. SANATORIUM, Midhurst, Sussex.—Junior Assistant Medical Officer, unmarried. Salary £100 per annum, with board, lodging, and attendance.

KINGSTON-UPON-HULL, CITY AND COUNTY OF.—Assistant Medical Officer of Health, unmarried. Salary £200 per annum, with residence, board, and washing.

LEICESTER INFIRMARY.—Assistant House Physician. Salary at rate of £50 per annum, with board, apartments, and washing. Also Second House Surgeon. Salary at rate of £100 per annum, with board, apartments, and washing.

LICHFIELD, COUNTY ASYLUM, Burntwood.—Junior Assistant Medical Officer, unmarried. Salary £150 per annum, with board, lodging, attendance, and washing.

LIVERPOOL EYE AND EAR INFIRMARY, Myrtle-street.—Two Honorary Anæsthetists.

LIVERPOOL INFIRMARY FOR CHILDREN.—House Surgeon. Salary £100 per annum, with board and lodging.

LIVERPOOL, ROYAL SOUTHERN HOSPITAL.—Resident Pathologist and Registrar. Salary £100, with board and residence.

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LONDON COUNTY ASYLUM, Horton, Epsom, Surrey.—Assistant Medical Officer, unmarried. Salary £160 per annum, with board, apartments, and washing.

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MANCHESTER, CHORLTON-UPON-MEDLOCK DISPENSARY. — Resident Medical Officer. Salary £120 per annum.

MANCHESTER EYE AND EAR HOSPITAL, 25, St. John-street, Deansgate.—Medical Officers for the Examination of School Children. Also Clinical Assistants.

MANCHESTER, ST. MARY'S HOSPITALS FOR WOMEN AND CHILDREN.—Resident Surgical Officer. Salary £100 per annum, with board and residence.

METROPOLITAN HOSPITAL, Kingsland-road, N.E.—Assistant Surgeon.

MILLER GENERAL HOSPITAL, Greenwich-road, S.E.—Physician to In-Patients. Also Surgeon to In-Patients. Also Junior House Surgeon for six months. Salary at rate of £80 per annum.

MOUNTAIN ASH URBAN DISTRICT EDUCATION COMMITTEE.—School Medical Officer. Salary £250 per annum.

NEW HOSPITAL FOR WOMEN.—Two House Surgeons (females).

NORTHAMPTON, COUNTY BOROUGH OF.—Assistant Medical Officer of Health. Salary £200 per annum, rising to £250.

OLDHAM, COUNTY BOROUGH OF.—Assistant Schools Medical Officer. Salary £200 per annum, rising to £260.

POPLAR AND STEPNEY SICK ASYLUM, Bromley, E.—Second Assistant Medical Officer. Salary £100 per annum, with rations, apartments, and washing.

PRINCE OF WALES'S GENERAL HOSPITAL, Tottenham, N.—Junior House Physician. Salary £40 per annum, with residence, board, and laundry.

QUEEN'S HOSPITAL FOR CHILDREN, Hackney-road, Bethnal Green, E.—Two House Surgeons for six months. Salaries at rate of £60 per annum, with board, residence, and laundry.

RANGOON MUNICIPALITY.—Health Officer. Salary Rs.1000, rising to Rs.1500 per mensem.

ROYAL GENERAL DISPENSARY, 25 and 26, Bartholomew's-close, E.C.—Physician. Salary £40 per annum.

ROYAL WATERLOO HOSPITAL FOR CHILDREN AND WOMEN, S.E.—Junior Resident Medical Officer. Salary at rate of £40 per annum, with board and washing.

ST. GEORGE'S UNION INFIRMARY, Fulham-road, London, S.W.—Second Assistant Medical Officer. Salary £120 per annum, with board, residence, and washing.

SHREWSBURY, SALOP INFIRMARY.—House Physician. Salary at rate of £60 per annum, with board and apartments.

SOUTH AFRICA, PROVINCIAL HOSPITAL, Port Elizabeth.—Assistant House Surgeon, unmarried. Salary £225, rising to £300 per annum, with board and residence.

STOKE-ON-TRENT, NORTH STAFFORDSHIRE INFIRMARY AND EYE HOSPITAL, Hartshill.—Junior House Surgeon. Salary £50 per annum, with board, apartments, and washing.

SYRIA, LEBANON HOSPITAL FOR THE INSANE, Asfuriyeh.—Medical Superintendent. Salary £300 per annum and house.

WEST LONDON HOSPITAL AND POST-GRADUATE COLLEGE, Hammersmith-road, W.—Clinical Assistants also Casualty Officers.

WESTERN AUSTRALIA, HOSPITAL FOR THE INSANE.—Senior Assistant Medical Officer, unmarried. Salary £380, rising to £405 per annum, with board, lodging, washing, fuel, and light. Also Junior Assistant Medical Officer. Salary £285, rising to £315 per annum, with board, lodging, washing, fuel, and light.

WESTERN GENERAL DISPENSARY, Marylebone-road, N.W.—Junior House Surgeon. Salary at rate of £80 per annum, with board, residence, and washing.

WESTON-SUPER-MARE HOSPITAL.—House Surgeon, unmarried. Salary £100 per annum, with board and residence.

WOLVERHAMPTON AND MIDLAND COUNTIES EYE INFIRMARY.—House Surgeon. Salary £80 per annum, with apartments, board, and laundry.

Births, Marriages, and Deaths.

BIRTHS.

DE ZILWA.—On May 8th, at 10, Rosmead-place, Cinnamon Gardens, Colombo, Ceylon, the wife of Lucian A. E. de Zilwa, M.D., B.Sc. Lond., of a daughter.

FRENCH.—On the 7th June, at 23, Porchester-gardens, Hyde Park, W., the wife of J. Gay French, M.B., M.S. Lond., F.R.C.S. Eng., of a son.

MARRIAGES.

BRAMWELL—CUNNINGHAM.—On June 3rd, at St. Cuthbert's Parish Church, Edinburgh, Edwin Bramwell, M.B., F.R.C.P. Edin. and Lond., to Elizabeth Cumming, elder daughter of D. J. Cunningham, F.R.S., Dean of the Faculty of Medicine in the University of Edinburgh.

DEATHS.

BULLMORE.—On Thursday, June 4th, at Arwenack, Falmouth, W. King Bullmore, M.D., aged 74.

N.B.—A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.

Notes, Short Comments, and Answers to Correspondents.

TATTOOING.

AN interesting article on tattooing in the U.S. Navy appears in the April issue of the *United States Naval Medical Bulletin* by Surgeon Ammen Farenholt, U.S. Navy, attached to U.S.S. *Independence* at the Mare Island Navy Yard, California. He says: "I have recently examined the enlistment records of 3572 men, being the enlistments on this vessel for a period of eight and a half years, and have obtained the following data for that portion of our enlisted force percentage of men found tattooed on examination for second and subsequent enlistments, 53·61; percentage of men found to be tattooed on examination for first enlistment, 23·01. While the former figures give a fair estimate of tattooing among the 'old timers' it is a trifle under the correct estimate for the service as a whole, and I think it would be nearer the truth to say that about 60 per cent. of persons who have served over ten years are thus marked. On the other hand, it is not fair to assume that 23 per cent. of all male civilians are tattooed because that was found to be the percentage among those who presented themselves for first enlistment, as a considerable proportion of applicants are seafaring men, and as it is probable that some men conceal previous service." The designs were found to have been placed in the following locations according to numerical preponderance: (1) forearms, (2) arms, (3) chest, (4) shoulders, (5) hands, (6) wrists, (7) legs, (8) feet, (9) back, and (10) face. The conventional designs in order of frequency were the following (1) letters, (2) coats-of-arms, (3) flags, (4) anchors, (5) eagles and birds, (6) stars, (7) female figures, (8) ships, (9) clasped hands, (10) daggers, (11) crosses, (12) bracelets, and (13) hearts. Further particulars of Surgeon Farenholt's paper may be seen in the *Naval and Military Record* of May 21st, which has made a long quotation from the article. Those who are interested in tattooing will find some further information easily accessible in an annotation which appeared in THE LANCET of March 9th, 1872, p. 341, which gave a summary of various methods of tattooing, and in the "Twentieth Century Practice of Medicine," Vol. XII., p. 382, which contains an interesting article by Professor Cesare Lombroso. Surgeon Farenholt states that the custom probably originated among the natives of the South Sea Islands, but Professor Lombroso refers to Herodotus having observed the custom in his time. The orthodox origin is that some Scythian ladies caused some Thracian female captives to be so marked for purposes of derision, but that it afterwards became a fashion.

A few particulars of tattooing in the South Sea Islands will be found in the "Narrative of Missionary Enterprises in the South Sea Islands," by John Williams, the "Missionary of Polynesia," who was so tragically murdered in 1839. He there says: "Some were tattooed from head to foot. Some were painted most fantastically with pipe-clay and yellow and red ochre. Others were smeared with charcoal. The King Makea (of Rarotonga) was most beautifully tattooed and slightly coloured with a preparation of turmeric and ginger which gave it a light orange tinge." Speaking of another island he says: "Few of the women were tattooed, but many of them were spotted. This is what they call *sengisengi*, and is effected by raising small blisters with a wick of native cloth, which burns, but does not blaze. When they are healed they leave the spot a shade lighter than the original skin. Thus indelible devices are imprinted. They adopt this method at Samoa, and tattooing at other islands to perpetuate the memory of some important event or beloved and departed relative."

Biblical students think that the following reference in Leviticus xix. 28 has reference to what is now known as tattooing: "Ye shall not make any cuttings in your flesh for the dead, nor print any marks upon you: I am the Lord." But there is no doubt that it has been very frequent among the Polynesians and the Maori chiefs of New Zealand and the Japanese, Burmese, and Siamese. With the New Zealanders the more the marks the greater the rank was the rule. The traffic in the tattooed heads of New Zealand chiefs caused such a scandal in 1830 that it was stopped by the British Governor, Darling. Tattooing was the cause of some losing their heads it was said. The chief reason of tattooing seems to have been to insure some sign of identity in battle.

Tattooing has also been employed for motives of religion, love and vendetta, distinction, and pure love of ornament. Criminals seem to have employed it for mixed motives of recognition or fancy. It has also been employed to restore natural colours in parts which are pigmented. Those who desire to have tattoo marks removed may find profit by referring to a paragraph which appeared in THE LANCET of Nov. 30th, 1907, p. 1585. Soldiers and sailors have always been partial to tattooing and we understand that the Bethnal Green police are now trying to establish the identity of a man, apparently an old soldier, who said that he had served in Burma, who died in the Vicar of Wakefield public-house, Bethnal Green, while he was smoking a cigarette. At Bethnal Green mortuary the man's body was found to be tattooed most elaborately all over, the designs including dancing girls, swords, crossed hands, and snakes. He was about 35 years old and a letter bearing the name of Albert Francis Candell was found in the clothing. Those of our soldiers and sailors who favour tattooing may not find it an unmixed distinction. There is danger in interfering with the natural functions of the skin and also the danger of conveying specific disease and the operation should not be lightly or carelessly undertaken, and in many cases it would be better not to undergo it at all.

"BLOWN" MEAT.

AT Brighton on June 2nd Benjamin Firth Kettle, cattle-dealer, Hassocks, and Louis Neary, butcher, Hurst, were each fined £2 10s. and costs, the former for depositing in Brighton for the purpose of sale, and intended for the food of man, a quantity of unsound meat, and the latter for being in possession of the meat. The meat consisted of two fore-quarters, a hind-quarter, and the head and pluck of an old ewe, and the evidence of Dr. Duncan Forbes, medical officer of health, showed that the lung was extensively affected by parasitic disease, the carcass was emaciated, and the meat wet and flabby. It was stated by the sanitary inspector that air had been blown into the cellular tissues to make the carcass appear plump and to hide the emaciation, and that such a practice was common in the south in the case of lamb and veal, but not in the case of mutton. The prosecution contended that it was Kettle's custom not to deal with butchers but to visit public-houses and restaurants and to offer meat for sale. This was denied. However, a quarter of this particular ewe was discovered at a public-house and seized. The fine of £2 10s. seems to be hardly sufficient to act as a deterrent to what no doubt has been a very lucrative trade in unsound meat.

"AS OTHERS SEE US."

To the Editor of THE LANCET.

SIR,—The following story overheard in a railway train recently is instructive as well as amusing. My fellow-passengers were four middle-class respectable women, and were all apparently strangers to each other and to me. One was suffering from a severe cough and the conversation turned to medicine and doctors, when one of the others declared she had had "asthma" for years and had gone to several doctors who "could do nothing" for her, and now she triumphantly asserted a chemist had given her a "chest protector" which she exhibited (!) and it had cured her.

The second woman chimed in and related how she had "saved her child's life" after the doctor had given her up by giving "Turkey rhubarb, manna, and rose leaves," a prescription she had seen in a newspaper. The doctor could not understand how the child recovered and she did not tell him, as once before he had laughed when she informed him she had given saffron tea to the children when they had measles, and "every mother knew it was the best thing"! The third story, however, was the most marvellous and was told in dramatic style. Her daughter, aged 12, had been attended by a doctor for several weeks for St. Vitus's dance, but with no improvement, and he advised a visit to the seaside. They went to Southport and the next day a woman overtook them and remarked: "I see your little girl has St. Vitus's dance; if you want to cure her send 5s. to Mr. X. at Lancaster and he will help you." She did, and received four powders with directions to give one a week at exactly the same hour and day. The first did no good; soon after the second the child could "keep her face straight"; after the third she "stopped jerking her arms," and ten minutes after the fourth powder "power came back to her legs and she passed a long worm"! There had been no relapse and it had happened some months ago. Cases have been recorded in THE LANCET (Pereira: THE LANCET, Sept. 19th, 1903, p. 824; Hodge: THE LANCET, Oct. 31st, 1903, p. 1232) of worms causing chorea and this was undoubtedly a case. The moral is obvious.

I am, Sir, yours faithfully,

Wakefield. A. F. THEOBALDS.

AN INCREASED SENTENCE ON A "SPECIALIST DOCTOR."

BERTRAM MORTIMORE, described as "an American specialist doctor," has furnished the first example of the increase of a sentence by the newly constituted Court of Criminal Appeal. Mortimore was sentenced to 15 months' hard labour for an offence not connected with his practice as a "specialist doctor," that of stealing a Gladstone bag from Victoria Station, but this sentence was afterwards reduced to the same period of incarceration in the second division. He appealed, and after hearing counsel on his behalf the Court of Criminal Appeal declined to grant him leave to call certain further evidence which he said he wished to lay before them, and also refused to say that the jury had been misdirected by the judge when his case was first tried. In addition to this, after mention had been made of Mortimore's antecedents, with which one of the judges composing the court happened to be acquainted, the sentence was restored to one of hard labour. The power to increase sentences upon appeal has been believed by lawyers to exist in those cases in which prisoners appeal to quarter sessions, but was never exercised so far as we are aware.

INDECENT ADVERTISEMENTS.

THE Joint Committee which is considering the question of lotteries and indecent advertisements and the adequacy or inadequacy of the present law in dealing with these matters held a sitting on June 1st, at which Mr. W. Vesey Harrel, M.V.O., Assistant Commissioner of the Dublin Metropolitan Police, gave some interesting evidence. He pointed out that in Ireland the police had the same problem before them as the English authorities have and gave it as his opinion that extended powers should be given to them for the searching of shops for the discovery of indecent wares. In one part of his evidence he uttered opinions which we have repeatedly expressed ourselves with

regard to the necessity for a wider definition of the words "indecent or obscene" and increased penalties for those guilty of obscene publication. Mr. Harrel thought that the printers and publishers of "literature" referring to medicines and appliances for the treatment of sexual disorders ought to be made liable to prosecution. This is a point which has been abundantly clear to us for a long time. The vendors of abortifacients (which may or may not cause abortion), of sexual invigorators which certainly do not invigorate, and of rubber goods are very generally the same persons. They carry on, and make money out of, an indecent trade. Claims made on behalf of their wares are false and they should be placed in the more immediate surveillance of the police.

HOSPITAL PEWTER.

LOVERS of the antique who gave an hour to the inspection of the pewter exhibited in the hall of Clifford's Inn last week have doubtless been comparing notes on the collections in their own hospitals—they happen to belong to one of the older institutions. St. Bartholomew's is justly proud of its possessions in this ancient metal, but perhaps it is not so well known that the little infirmary of the Foundling Hospital also rejoices in some very fine specimens. Among them are a handsome bowl and ewer, several "bleeding basins" with finely worked handles—reminiscent of the days of cupping and other forms of blood-letting—and a mug-shaped article with two openings at the top, to which have been assigned the alternative uses of a lamp or an inhaler. The question of how far back inhaling may have been practised is one for medical archæologists. One of the bleeding basins, which has a rather more elaborate handle than the others, is measured to hold 16 ounces. There is no clue forthcoming at present as to the date of the articles. They were found some time ago, covered with the dust of ages, in a cupboard in the old disused infirmary, and handed over to the care of the superintendent of the new one. The whole set is now kept as a prominent ornament in one of the wards, and may be seen by any visitors sufficiently interested in this great institution to penetrate as far as the infirmary.

Ethics.—1. It is not customary for a medical officer of health to inspect a patient who is suffering from infectious disease and whose condition has been notified by the practitioner in attendance in the usual way. The exceptions to this rule are the very rare cases where the health officer has strong reason to doubt the good faith of the certificate or where the certificate is not explicit—e.g., as in a notification of "continued fever"—or where the disease reported is exceptional and of grave danger to the community, such as cholera or typhus fever. 2. The medical officer of health has no legal right of entry to a sickroom, save when he can show a "nuisance" to exist therein and on that ground obtains a magistrate's order to enter. He has no right to inspect patients without their consent or that of their friends, and it is highly desirable that the coöperation of the medical practitioner in attendance should be obtained before a visit for such a purpose is made, and that the inspection of the patient should have the nature of a consultation between the practitioner and the health officer, the usual courtesies of a medical consultation being strictly observed. It would be unethical for a health officer to inspect a patient without at any rate acquainting the practitioner in attendance of his intention to do so. Our correspondent will find the whole matter discussed fully in a pamphlet published by THE LANCET containing reprints of a series of special articles entitled "Difficulties under the Infectious Disease (Notification) Act."

Westminster.—We presume that our correspondent wants to know what is the custom pursued in the best professional circles, for, of course, from an ethical point of view he can adopt any style of visiting card that he likes. In this country it is quite unusual for a medical man to be described on his visiting card more fully than he would be announced on entering a room. Our correspondent being engaged in ophthalmology should describe himself simply as Mr. ——; he should not put his honour degrees or his specialty as an ophthalmic surgeon on his card. In other countries, notably in America, the reverse obtains, and certainly makes for convenience.

J. W. R.—Will our correspondent kindly send us one of the certificate forms in question?

COMMUNICATIONS not noticed in our present issue will receive attention in our next.

METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET Office, June 11th, 1908.

Date.	Barometer reduced to Sea Level and 32° F.	Direction of Wind.	Rainfall.	Solar Radio in Vacuo.	Maximum Temp. Shade.	Min. Temp.	Wet Bulb.	Dry Bulb.	Remarks.
June 5	30·02	N.	0·23	118	68	56	53	58	Cloudy
,, 6	29·93	N.W.	...	97	56	50	48	54	Cloudy
,, 7	30·21	N.E.	...	103	62	45	45	51	Cloudy
,, 8	30·14	N.W.	...	110	68	51	52	59	Cloudy
,, 9	30·22	N.W.	0·02	107	70	49	53	55	Raining
,, 10	30·30	N.W.	0·01	124	75	55	61	66	Cloudy
,, 11	30·23	S.W.	...	126	68	57	58	63	Cloudy

Medical Diary for the ensuing Week.

SOCIETIES.

ROYAL SOCIETY OF MEDICINE, 20, Hanover-square, W.

TUESDAY.

SURGICAL SECTION (Hon. Secretaries—Stephen Paget, H. F. Waterhouse): at 5.30 P.M.

Mr. Walter G. Spencer: Reduction of an Old Sub-coracoid Dislocation of the Humerus by Excavating the Glenoid Cavity through a Posterior Intermuscular Incision.

Mr. Alban Doran: Cystic Tumour of the Suprarenal Body successfully Removed by Operation

Mr. Rushton Parker: (1) Cases of Non-union treated by Implantation of Bone Fragments; (2) Case of very severe Compound Fracture of Arm.

(Illustrated by photographs and lantern slides).

THURSDAY.

NEUROLOGICAL SECTION (Hon Secretaries—Leonard G. Guthrie, E. Farquhar Buzzard): at 4.30 P.M.

Clinical Meeting (at the Hospital for Epilepsy and Paralysis, 4, Maida-vale).

DERMATOLOGICAL SECTION (Hon. Secretaries—A. Whitfield, E. G. Graham Little): at 5 P.M.

Clinical Cases:

Dr. Graham Little: (1) Private Case for Diagnosis; (2) Private Case of Urticaria Pigmentosa in an Adult (with sections); (3) Two Cases of Pseudo-pelade (Brocq); (4) Sections of Skin from the Case for Diagnosis and the "Varus Nodulosus" shown at the last meeting.

(*And other Cases not yet notified*).

N.B.—Fellows of the Society are entitled to attend and to speak at all Meetings.

SOCIETY FOR THE STUDY OF INEBRIETY, 11, Chandos-street, Cavendish-square, W.

TUESDAY.—3.30 P.M., Council Meeting. 4 P.M., Discussion on Alcoholism and Cruelty to Children (opened by Mr. R. J. Parr).

SOCIETY OF TROPICAL MEDICINE AND HYGIENE, 20, Hanover-square, W.

FRIDAY.—8.30 P.M., Annual General Meeting. Dr. C. F. Harford: Tick Fever of Africa, with Special Reference to its Clinical Manifestations and its Relation to the Relapsing Fever of India and other parts of the World.

LECTURES, ADDRESSES, DEMONSTRATIONS, &c.

ROYAL COLLEGE OF PHYSICIANS OF LONDON, Pall Mall East.

THURSDAY.—5 P.M., Croonian Lecture:—Dr. A. E. Garrod: Inborn Errors of Metabolism.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC, 22, Chenies-street, W.C.

MONDAY.—4 P.M., Dr. J. H. Sequeira: Clinique (Skin). 5.15 P.M., Lecture:—Prof. T. Hewlett: The Diagnosis of Syphilis, &c., by the Antigen Method.

TUESDAY.—4 P.M., Dr. E. Cautley: Clinique (Medical). 5.15 P.M., Lecture:—Mr. H. Evans: Injuries to the Head of the New Born (with lantern slides).

WEDNESDAY.—4 P.M., Mr. R. Johnson: Clinique (Surgical) 5.15 P.M., Lecture:—Mr. C. R. B. Keetley: Affections of the Toes, Feet, and Ankles.

THURSDAY.—4 P.M., Mr. Hutchinson: Clinique (Surgical). 5.15 P.M., Lecture:—Dr. W. Langdon Brown: Diseases associated with Cyanosis.

FRIDAY.—4 P.M., Mr. A. Lawson: Clinique (Eye).

POST-GRADUATE COLLEGE, West London Hospital, Hammersmith-road, W.

MONDAY.—12 noon, Lecture:—Dr. Low: Pathological Demonstration. 2 P.M., Medical and Surgical Clinics. X Rays. Mr. Dunn: Diseases of the Eyes. 2.30 P.M., Operations. 5 P.M., Lecture:—Mr. Bidwell: Plaster of Paris Splints.

TUESDAY.—10 A.M., Dr. Moullin: Gynæcological Operations. 2 P.M., Medical and Surgical Clinics. X Rays. 2.15 P.M., Dr. Davis: Diseases of Throat, Nose, and Ear. 2.30 P.M., Operations. Dr. Abraham: Diseases of the Skin. 5 P.M., Lecture:—Mr. Armour: Lymphatic Gland Enlargements.

WEDNESDAY.—10 A.M., Dr. Saunders: Diseases of Children. 12.15 P.M., Lecture:—Dr. Pritchard: Practical Medicine. 2 P.M., Medical and Surgical Clinics. X Rays. Dr. Scott: Diseases of the Eyes. 2.30 P.M., Operations. 5 P.M., Lecture:—Mr. Armour: Thyroid Enlargements.

THURSDAY.—2 P.M., Medical and Surgical Clinics. X Rays. Mr. Dunn: Diseases of the Eyes. 2.30 P.M., Operations. 5 P.M., Lecture:—Mr. Baldwin: Practical Surgery.

FRIDAY.—10 A.M., Dr. Moullin: Gynæcological Operations. 12.15 P.M., Lecture:—Dr. Pritchard: Practical Medicine. 2 P.M., Medical and Surgical Clinics. X Rays. 2.15 P.M., Dr. Davis: Diseases of Throat, Nose, and Ear. 2.30 P.M., Operations. Dr. Abraham: Diseases of the Skin. 5 P.M., Lecture:—Dr. R. H. Cole: Medico-legal Relations of Insanity.

SATURDAY.—10 A.M., Dr. Saunders: Diseases of Children. 2 P.M., Medical and Surgical Clinics. X Rays. Dr. Scott: Diseases of the Eyes. 2.30 P.M., Operations.

NORTH-EAST LONDON POST-GRADUATE COLLEGE, Prince of Wales's General Hospital, Tottenham, N.

MONDAY.—Clinics:—10 A.M., Surgical Out-patient (Mr. J. H. Evans). 2.30 P.M., Medical Out-patient (Dr. Whipham); Nose, Throat, and Ear (Mr. Carson); X Rays. 4.30 P.M., Medical In-patient Clinic (Dr. Whiting).

TUESDAY.—Clinic:—10 A.M., Medical Out-patient (Dr. Auld). 2.30 P.M., Surgical Operations (Mr. Carson). Clinics:—Surgical (Mr. Edmunds); Gynæcological (Dr. Giles). 4.30 P.M., Demonstration of Cases at the Northwood Sanatorium (Dr. Squire).

WEDNESDAY.—Clinics:—2.30 P.M., Medical Out-patient (Dr. Whipham); Skin (Dr. Meachen); Eye (Mr. Brooks).
THURSDAY.—2.30 P.M., Special Demonstration of Gynæcological Operations (Dr. Giles). Clinics:—Medical Out-patient (Dr. Whiting); Surgical (Mr. Carson); X Rays. 3 P.M., Medical In-patient (Dr. Chappel). 4.30 P.M., Demonstration of Selected Medical Cases (Dr. Whiting).
FRIDAY.—10 A.M., Clinic:—Surgical Out-patient (Mr. J. H. Evans). 2.30 P.M., Surgical Operations (Mr. Edmunds). Clinics:—Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 P.M., Medical In-patient (Dr. R. M. Leslie).

LONDON SCHOOL OF CLINICAL MEDICINE, Dreadnought Hospital, Greenwich.

MONDAY.—2.15 P.M., Sir Dyce Duckworth: Medicine. 2.30 P.M., Operations. 3.15 P.M., Mr. W. Turner: Surgery. 4 P.M., Mr. L. A. Lawrence: Ear and Throat. Out-patient Demonstrations:—10 A.M., Surgical and Medical. 12 noon, Ear and Throat.
TUESDAY.—2.15 P.M., Dr. R. T. Hewlett: Medicine. 2.30 P.M., Operations. 3.15 P.M., Mr. Carless: Surgery. 4 P.M., Sir M. Morris: Diseases of the Skin. Out-patient Demonstrations:—10 A.M., Surgical and Medical. 12 noon, Skin.
WEDNESDAY.—2.15 P.M., Dr. F. Taylor: Medicine. 2.30 P.M., Operations. 3.30 P.M., Mr. Cargill: Ophthalmology. Out-patient Demonstrations:—10 A.M., Surgical and Medical. 11 A.M., Eye.
THURSDAY.—2.15 P.M., Dr. G. Rankin: Medicine. 2.30 P.M., Operations. 3.15 P.M., Sir W. Bennett: Surgery. 4 P.M., Mr. M. Davidson: Radiography. Out-patient Demonstrations:—10 A.M., Surgical and Medical. 12 noon, Ear and Throat.
FRIDAY.—2.15 P.M., Dr. R. Bradford: Medicine. 2.30 P.M., Operations. 3.15 P.M., Mr. McGavin: Surgery. Out-patient Demonstrations:—10 A.M., Surgical and Medical. 12 noon, Skin. Special Lecture:—Dr. R. Bradford: Peripheral Neuritis.
SATURDAY.—2.30 P.M., Operations. Out-patient Demonstrations:—10 A.M., Surgical and Medical. 11 A.M., Eye.

NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC, Queen-square, Bloomsbury, W.C.

TUESDAY.—3.30 P.M., Lecture:—Dr. Collier: Amyotonia Congenita.
FRIDAY.—3.30 P.M., Lecture:—Dr. Collier: Caisson Disease.

ROYAL INSTITUTE OF PUBLIC HEALTH, Theatre of the Institute, 37, Russell-square, W.C.

WEDNESDAY.—5 P.M., Harben Lecture:—Prof. G. H. F. Nuttall: Spriochætosis in Man and Animals.

MEDICAL OFFICERS OF SCHOOLS ASSOCIATION, 11, Chandos-street, Cavendish-square, W.

WEDNESDAY.—3.30 P.M., Discussion on the Recent Memorandum passed by the Board of Education to Local Education Authorities *re* the Medical Inspection of Elementary Schools (opened by Mr. J. Hayward).

OPERATIONS.

METROPOLITAN HOSPITALS.

MONDAY (15th).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), St. George's (2 P.M.), St. Mary's (2.30 P.M.), Middlesex (1.30 P.M.), Westminster (2 P.M.), Chelsea (2 P.M.), Samaritan (Gynæcological, by Physicians, 2 P.M.), Soho-square (2 P.M.), City Orthopædic (4 P.M.), Gt. Northern Central (2.30 P.M.), West London (2.30 P.M.), London Throat (9.30 A.M.), Royal Free (2 P.M.), Guy's (1.30 P.M.), Children, Gt. Ormond-street (9 A.M.), St. Mark's (2.30 P.M.), West London (2.30 P.M.).

TUESDAY (16th).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), Guy's (1.30 P.M.), Middlesex (1.30 P.M.), Westminster (2 P.M.), West London (2.30 P.M.), University College (2 P.M.), St. George's (1 P.M.), St. Mary's (1 P.M.), St. Mark's (2.30 P.M.), Cancer (2 P.M.), Metropolitan (2.30 P.M.), London Throat (9.30 A.M.), Samaritan (9.30 A.M. and 2.30 P.M.), Throat, Golden-square (9.30 A.M.), Soho-square (2 P.M.), Chelsea (2 P.M.), Central London Throat and Ear (2 P.M.), Children, Gt. Ormond-street (9 A.M. and 2 P.M., Ophthalmic, 2 P.M.), Tottenham (2.30 P.M.).

WEDNESDAY (17th).—St. Bartholomew's (1.30 P.M.), University College (2 P.M.), Royal Free (2 P.M.), Middlesex (1.30 P.M.), Charing Cross (3 P.M.), St. Thomas's (2 P.M.), London (2 P.M.), King's College (2 P.M.), St. George's (Ophthalmic, 1 P.M.), St. Mary's (2 P.M.), National Orthopædic (10 A.M.), St. Peter's (2 P.M.), Samaritan (9.30 A.M. and 2.30 P.M.), Gt. Northern Central (2.30 P.M.), Westminster (2 P.M.), Metropolitan (2.30 P.M.), London Throat (9.30 A.M.), Cancer (2 P.M.), Throat, Golden-square (9.30 A.M.), Guy's (1.30 P.M.), Royal Ear (2 P.M.), Royal Orthopædic (3 P.M.), Children, Gt. Ormond-street (9 A.M. and 9.30 A.M., Dental, 2 P.M.), Tottenham (Ophthalmic, 2.30 P.M.), West London (2.30 P.M.).

THURSDAY (18th).—St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), University College (2 P.M.), Charing Cross (3 P.M.), St. George's (1 P.M.), King's College (2 P.M.), Middlesex (1.30 P.M.), St. Mary's (2.30 P.M.), Soho-square (2 P.M.), North-West London (2 P.M.), Gt. Northern Central (Gynæcological, 2.30 P.M.), Metropolitan (2.30 P.M.), London Throat (9.30 A.M.), Samaritan (9.30 A.M. and 2.30 P.M.), Throat, Golden-square (9.30 A.M.), Guy's (1.30 P.M.), Royal Orthopædic (9 A.M.), Royal Ear (2 P.M.), Children, Gt. Ormond-street (9 A.M. and 2 P.M.), Tottenham (Gynæcological, 2.30 P.M.), West London (2.30 P.M.).

FRIDAY (19th).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), Guy's (1.30 P.M.), Middlesex (1.30 P.M.), Charing Cross (3 P.M.), St. George's (1 P.M.), King's College (2 P.M.), St. Mary's (2 P.M.), Ophthalmic (10 A.M.), Cancer (2 P.M.), Chelsea (2 P.M.), Gt. Northern Central (2.30 P.M.), West London (2.30 P.M.), London Throat (9.30 A.M.), Samaritan (9.30 A.M. and 2.30 P.M.), Throat, Golden-square (9.30 A.M.), City Orthopædic (2.30 P.M.), Soho-square (2 P.M.), Central London Throat and Ear (2 P.M.), Children, Gt. Ormond-street (9 A.M., Aural, 2 P.M.), Tottenham (2.30 P.M.), St. Peter's (2 P.M.).

SATURDAY (20th).—Royal Free (9 A.M.), London (2 P.M.), Middlesex (1.30 P.M.), St. Thomas's (2 P.M.), University College (9.15 A.M.), Charing Cross (2 P.M.), St. George's (1 P.M.), St. Mary's (10 A.M.), Throat, Golden-square (9.30 A.M.), Guy's (1.30 P.M.), Children, Gt. Ormond-street (9 A.M. and 9.30 A.M.), West London (2.30 P.M.).

At the Royal Eye Hospital (2 P.M.), the Royal London Ophthalmic (10 A.M.), the Royal Westminster Ophthalmic (1.30 P.M.), and the Central London Ophthalmic Hospitals operations are performed daily.

EDITORIAL NOTICES.

IT is most important that communications relating to the Editorial business of THE LANCET should be addressed *exclusively* "TO THE EDITOR," and not in any case to any gentleman who may be supposed to be connected with the Editorial staff. It is urgently necessary that attention should be given to this notice.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this office.

Lectures, original articles, and reports should be written on one side of the paper only, AND WHEN ACCOMPANIED BY BLOCKS IT IS REQUESTED THAT THE NAME OF THE AUTHOR, AND IF POSSIBLE OF THE ARTICLE, SHOULD BE WRITTEN ON THE BLOCKS TO FACILITATE IDENTIFICATION.

Letters, whether intended for insertion or for private information, must be authenticated by the names and addresses of their writers—not necessarily for publication.

We cannot prescribe or recommend practitioners.

Local papers containing reports or news paragraphs should be marked and addressed "To the Sub-Editor."

Letters relating to the publication, sale and advertising departments of THE LANCET *should be addressed "To the Manager."*

We cannot undertake to return MSS. not used.

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WILL Subscribers please note that only those subscriptions which are sent direct to the Proprietors of THE LANCET at their Offices, 423, Strand, London, W.C., are dealt with by them? Subscriptions paid to London or to local newsagents (with none of whom have the Proprietors any connexion whatever) do not reach THE LANCET Offices, and consequently inquiries concerning missing copies, &c., should be sent to the Agent to whom the subscription is paid, and *not* to THE LANCET Offices.

Subscribers, by sending their subscriptions direct to THE LANCET Offices, will insure regularity in the despatch of their Journals and an earlier delivery than the majority of Agents are able to effect.

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SUBSCRIBERS ABROAD ARE PARTICULARLY REQUESTED TO NOTE THE RATES OF SUBSCRIPTIONS GIVEN ABOVE. It has come to the knowledge of the Manager that in some cases higher rates are being charged, on the plea that the heavy weight of THE LANCET necessitates additional postage above the ordinary rate allowed for in the terms of subscriptions. Any demand for increased rates, on this or on any other ground, should be resisted. The Proprietors of THE LANCET have for many years paid, and continue to pay, the whole of the heavy cost of postage on overweight foreign issues; and Agents are authorised to collect, and generally do so collect, from the Proprietors the cost of such extra postage.

During the week marked copies of the following newspapers have been received:—*Liverpool Courier, Northern Whig, New Zealand Herald, Glasgow Times, Glasgow Evening Times, Birmingham Despatch, Morning Post, Times of India, Aberdeen Free Press, Wimborne Herald, Newcastle Daily Chronicle, Yorkshire Daily Post, Hampshire Advertiser, Aberdeen Gazette, Weekly Scotsman, Ipswich Star, North Star, Newcastle Weekly Journal, The Schoolmaster, &c.*

Communications, Letters, &c., have been received from—

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THE LANCET

SPECIAL SUPPLEMENT

IN SUPPORT OF THE

METROPOLITAN HOSPITAL SUNDAY FUND

Published in aid of the Appeal to be made on Sunday, June 21st, 1908.

"So many are
The sufferings which no human aid can reach
It needs must be a duty doubly sweet
To heal the few we can."—COLERIDGE.

FOR more than twenty years THE LANCET has claimed the aid of those into whose hands its Supplement may fall on behalf of the suffering poor of London, and of the Metropolitan Hospital Sunday Fund. The appeal thus made on "Hospital Sunday" is addressed in the first place to those who, on that day, attend religious services in places of worship where collections in aid of the Fund take place, or in the case of members of the Jewish faith to those who on the preceding Saturday have the opportunity of contributing brought directly to their notice. In the second place it is hoped and believed that many who on the two days mentioned are not attending Divine worship in London or in any other locality where collections are being made on behalf of the Metropolitan Hospital Sunday Fund nevertheless will desire to aid. And all who have it in their power to do so are urged to remind these absentees to give, as well as to give themselves. Moreover the putting of it into the mind of others to give may well play an important part in the present year, 1908, for not only in the ordinary course of metropolitan life in summer many who usually dwell in London will be absent from it on Hospital Sunday, but there are also in our midst an unusual number of foreigners. At peace with all mankind, we are celebrating and cementing our friendship with the great nation across the Channel in a joint exhibition held in order to display to one another and to the world our achievements in the spheres of industry and of art, while the great exhibition does not stand alone as an attraction to bring foreigners within our walls. Those who come do so either in the pursuit of pleasure or of profit; it is not to be supposed that they will grudge a contribution to our great charities if they are but made aware of their existence and of their needs. The beggar knows well in all countries that in the foreigner he will find a sympathetic listener to his tale. The tale told by the hospitals is an oft-told story of need, of life lived from hand to mouth, of suffering endured by men and women; but, unlike that of other mendicants, their need is real; they work as well as beg, and it is on behalf of others that they work, it is upon others that they bestow the alms which they obtain; their doors are opened to native-born Briton and to foreigner alike. May we not then urge that all who have the power to do so should bring the Metropolitan Hospital Sunday Fund's need home to our visitors. If they are attending Divine worship in our midst they will become aware that Hospital Sunday is a special occasion falling but once a year, but otherwise they may leave London without ever hearing of the existence of the Metropolitan Hospital Sunday Fund. To remind others may be to some a less welcome duty than to give themselves, but none the less the Fund cannot afford to lose because it has failed to draw attention to itself at the right moment. To all, therefore, we appeal to influence the generosity of others no less than to exercise their own.

Why all should give.

We are aware that we are dwelling upon a tale not twice told but re-iterated many times in the past, and to be repeated by us, we hope, during many years to come, when we press the claims of the hospitals upon all, making no exceptions, and "sparing neither age nor sex." Neither rich nor poor can claim any right to be exempt from a tax to which all are invited to assess themselves according to their means, and from which all will benefit, in varying degrees, according to their needs. When a sudden emergency occurs, and the rich man injured in a street accident requires that aid which would come too late if he were to wait to be conveyed to his house or to the private nursing home, the doors of the hospital are open to him, and he may be carried through them side by side with some nameless

wanderer, some worker who has been struck down while toiling to earn his daily bread, some victim of crime or the criminal himself who has brought himself to death's door in the act of wronging his fellow man. To all in their need the hospital ward is open so long as there is a bed on which to lay the patient who needs assistance; but the maintenance of those beds is a matter which has to be paid for, and what if there be none standing empty when the urgent case comes in? What if space which beds might occupy is standing vacant, because there is no money to provide for them and for their upkeep? In such an event the man in need, whether rich or poor, must be turned away to seek admission elsewhere, but we would urge upon all not to allow such a possibility to exist. Moreover the debt owed to the hospitals by those well-provided with this world's goods is not one which they can avoid by steering clear of such mishaps as we have suggested. Whenever they are compelled to have recourse to the medical profession, from the day of their entrance into the world until they pass out of it, they are under obligation to the hospitals for the skill and knowledge used for their benefit by those who have had their training in the hospitals, and who could have acquired it nowhere else.

When, however, we speak of "rich" and "poor" in their relation to the hospitals, we are using terms which are frequently employed to contrast two extreme social conditions, but which omit that most important class to which the Metropolitan Hospital Sunday Fund looks indeed with gratitude and with confidence for support, but from which it ever hopes to receive even more substantial assistance. If the word "poor" may be taken as representing those whose need may render them at any time inmates of hospitals, and if it is conceded that from that class many contribute out of direct gratitude for benefits received, it must be admitted, nevertheless, that the income to be derived from the gifts of the poor themselves must be but small in relation to the sum required. On the other hand, the "rich," the unquestionably and admittedly wealthy, as distinguished from the merely "well-to-do" and "comfortably off," give largely, both in their lifetimes and by bequests to take effect after their deaths. On any day these legacies may be read of in the newspapers, and we have only to turn to the particulars with regard to the Metropolitan Hospital Sunday Fund in past years to see how important a part has been played by donors such as the late Mr. George Herring, and others whose names are worthily commemorated by their generosity. But between rich and poor in this vast commercial metropolis lies a great public within whose power it is to raise the Fund's annual contribution to the maintenance of our hospitals to a point higher than it has ever yet attained, and to keep it increasing steadily in proportion to the increasing demand. It is to this public that we appeal earnestly and insistently, and we do so because the hospitals of London cannot get on without their help; because the hospitals of London are unsurpassed among the world's most noble and ennobling institutions, and because we know that the appeal must be responded to universally, and the help given lavishly if the response is to be truly worthy of the occasion.

The Increasing Need and its Causes.

What is it that renders the petition of the hospitals for alms on behalf of the sick and injured poor more urgent year by year? Why is it not possible for them to keep their expenditure at the same level at which it was when the old men of to-day were young, or even by superior economy to reduce it? The answer is because there are more poor to serve in and round an ever-growing metropolis, and because those who support the hospitals by their gifts rightly expect the highest standard of service to be maintained. Each individual institution must go forward, or it will go back. In an age of progress it must keep itself in the condition of efficiency upon which modern benevolence insists, and much as the poor of past epochs have owed to the charity of their contemporaries, and deeply as many foundations now existing are indebted to the prudent forethought and well-devised generosity of the donors of the past, modern charity aims at ideals which bear but little resemblance to the standards which once held good. From an old book, "The Picture of London," published in 1818, we quote a single sentence praising the treatment meted out to patients in those days in what the writer evidently considered high terms of laudation. "The medical assistance is the best the profession can supply; the attendance is ample, and the persons employed in that office as humane as its nature admits, the rooms cleanly, and as wholesome as care can render the dwelling of a multitude of diseased persons, and the food is proper for the condition of the patient." We can picture the simplicity of the arrangements thus described. It is satisfactory to recall that the medical profession gave then, as now, their best skill freely for the relief of the needs of the poor. There is no increase of expenditure on that behalf—they give it still. But the change in every other direction has been enormous. The increase has been in the provision of buildings suited to modern requirements and to the obtaining of that scientific "cleanliness" which means life to patients who in the condition of comparative cleanliness indicated above died in numbers which to-day would astound us; and in the provision of operating theatres, of medicine, and of apparatus of all kinds in connection with food and nursing, all designed for carrying out the measures which modern science has made necessary, and for the obtaining of results which the pioneers of science in the day when the sentence quoted was penned can scarcely have pictured in their most sanguine daydreams.

Past and Present Standards of Benevolence.

We have before us a little publication circulated privately among those engaged in the care of the sick in the infirmary of one of our metropolitan workhouses. Among other articles of interest to its readers is one contributed by a lady who to-day visits the patients there, and who in her younger days visited in like manner the sick paupers in another London workhouse, which we may take as an example of what was possible in the days when the middle-aged among us were children. The lady saw much which shocked and horrified her, she remonstrated in vain with members of the board of guardians responsible, with the master, and with the matron, the last of whom was sympathetic but powerless, and she did so without securing any improvement. Finally, however, the abuses, which may have been to some extent unusual, were brought to the ears of higher official authority, and a Poor Law Inquiry was held at which she was able to give evidence, and we cite passages from her own record of her testimony so given, and of her experiences, still remembered vividly, not in order to provoke comparison between the wards of a hospital of to-day and those of a workhouse infirmary in 1866 (the date of the inquiry), but rather to illustrate the vast change in public opinion which has taken place, and the altered standard of benevolence towards the poor which has been established in the space of half a century. The lady writes of the inquiry, "I was asked to state what I had gathered during my visits

to the wards for infirm and insane women. My evidence described how lunatics were confined in the same ward as patients suffering from chronic complaints such as cancer, under the charge of a pauper attendant who had not a particle of feeling, and who, in fact, appeared to be possessed with that inborn love of cruelty which seems innate in some strange natures." In explanation of the "pauper attendant," it must be mentioned that in the workhouse described the nurses for the sick in the infirmary were neither more nor less than inmates of the able-bodied women's ward, who were there usually because they were irreclaimable drunkards, and who were rewarded for their services as nurses by being allowed half a pint of beer at their supper.

STATISTICS OF HOSPITAL WORK IN LONDON DURING THE YEAR 1907.

TABLE I.—GENERAL HOSPITALS.*

N.B.—The figures referring to out-patients in these Tables represent the number of VISITS *paid by out-patients—*NOT *the* NUMBER *of out-patients.*

Name of hospital.	Hospital Sunday Fund award.	In-patients.	Relieved.	Cured.	Convalescent homes.	Remaining under treatment.	Died.	Out-patients' visits.	Accidents and emergencies
	£								
Charing Cross	1,496	2,162	830	1,132	119	128	218	75,080	9,668
French	393	929	286	560	280	46	37	14,305	1,733
German	661	1,592	460	879	247	117	136	74,221	3,696
Great Northern Central	1,268	2,282	665	1,160	99	152	244	75,744	7,089
Guy's	1,625	8,733	7,076		832	506	689	425,541	76,721
Hampstead General	314	670	—	—	—	48	47	12,074	851
Italian	217	839	153	675	20	32	25	38,037	196
Kensington General	238	238	32	175	10	8	13	40,885	3,106
King's College	1,457	2,473	684	1,363	160	195	42	48,364	6,681
London	6,500	14,288	5,323	6,370	2,094	745	1,292	570,375	17,224
London Homœopathic	462	1,105	401	439	37	81	78	51,520	1,592
Phillips' Memorial Homœopathic	50	140	38	90	5	6	6	2,858	17
London Temperance	785	1,322	306	819	32	94	120	74,666	18,692
Metropolitan	1,226	1,933	522	1,076	242	106	529	124,136	14,086
Mildmay	325	640	117	433	109	38	32	47,699	8,402
Miller Hospital and Royal Kent Dispensary	271	381	138	217	7	21	26	63,938	9,603
National Anti-Vivisection	—	235	24	201	4	15	10	21,775	1,271
North-West London	471	215	23	177	14	—	6	47,982	7,845
Poplar	574	1,371	—	—	44	75	127	77,992	18,128
Royal Free	1,371	2,109	1,786		256	157	174	103,068	25,355
St. George's	2,275	4,469	3,699		1,217	335	372	108,795	18,961
SS. John and Elizabeth	325	374	338		—	90	26	—	—
St. John's, Lewisham	206	264	45	150	—	37	22	1,784	—
St. Mary's	2,546	3,902	1,293	1,943	353	269	334	133,207	23,902
Seamen's Hospital Society	1,636	2,414	504	511	—	265	189	86,338	20,637
The Middlesex Hosp. and Convalescent Home	2,757	3,918	2,732		1,104	276	316	134,445	—
Tottenham. Prince of Wales'	639	1,258	220	725	21	93	166	81,346	—
University College	2,167	3,616	1,224	1,528	441	249	306	135,925	36,556
Walthamstow, &c.	157	466	36	360	7	30	33	12,000	2,278
Wandsworth, Bolingbroke	303	640	113	422	—	33	72	30,866	5,758
West Ham	601	588	76	323	16	57	45	104,033	12,016
West London	1,224	2,495	2,341		178	154	292	125,157	19,646
Westminster	1,625	2,626	2,380		410	177	246	75,552	9,710
	£36,185	70,687	13,510	21,728	8,358	4,635	6,269	3,019,710	381,420
Estimated to supply omissions	—	—	7,984	13,116	125	—	—	—	39,494
Total	£36,185	70,687	21,494	34,844	8,483	4,635	6,269	3,019,710	420,914

* We reproduce the term "General Hospitals" as employed by the Council of the Metropolitan Hospital Sunday Fund.

An exception was made in favour of Mrs. E., the cruel nurse above referred to, in that she received a wage in addition to her half-pint of beer, in consideration of the arduous nature of her services. She is described as a strong, muscular person, and she "kept a strong stick always at hand in case any patient should be noisy or refractory. If patients became violent her usual practice was to drag them by their hair down the passage and throw them headlong into the padded room. In one of my visits there on a very hot day it chanced that Mrs. E. had been called away for some reason and the ward, for the time, was left in charge of the wretched old pauper assistant. Hearing loud cries and moans proceeding from the passage as I entered, I threw open the door at once and became aware of a young woman fastened to a bedstead by means of a sheet, which was bound tightly round her confining her arms. The sun streamed on her face through the blindless window and her lips were parched and dry. The word 'water' sent me back in all haste to the ward, where I desired the woman who was taking Mrs. E.'s place to give me some at once. This she refused to do, saying that she did not dare do anything without orders." In the end the writer, from whose reminiscences we are quoting, herself discovered a mug and a tap and took the responsibility of giving a drink of water to the suffering patient. She was thanked with gratitude, but whether the person thus treated was supposed to be out of her mind or was being punished for insubordination as a patient, she did not discover. Referring again to the stick above mentioned, she writes, "On inquiry as to its use from the decrepit old creature who slept next to Mrs. E., I was told in a frightened whisper that the pain she suffered sometimes at nights made her groan aloud, but she always tried hard to prevent it, as so sure as she made a sound the stick was brought down upon her at once to make her silent." Once after seeing an old woman knocked down by Mrs. E. the lady visitor complained to the matron, but was told that nothing could be done while the system prevailed by which the so-called "nurses" were chosen from the inmates of the able-bodied women's ward. On the only occasion on which a complaint to the master was ventured upon his reply was a threat that the guardians would

exclude the visitor from the wards if she made a fuss. Of the care of children in the same institution we read in another passage, "There were usually two children sleeping in each bed, and to show what a total want of care and supervision there was here, I date to which these memories of a bygone workhouse refer. We do, however, invite our readers to try to imagine such things taking place in the present day in London, and to realize that the change which renders them impossible is due to an altered and developed

TABLE II.—SPECIAL HOSPITALS.

Name of hospital.	Hospital Sunday Fund award.	In-patients.	Relieved.	Cured.	Convalescent homes.	Remaining under treatment.	Died.	Out-patients' visits.	Accidents and emergencies
	£								
City of London for Diseases of Chest	812	964	907		—	132	57	64,592	—
Hospital for Consumption...	3,012	1,445	1,085		273	306	95	47,971	—
Mount Vernon Consumption	1,284	1,424	—	—	—	202	18	14,171	—
Royal Hospital for Diseases of Chest	569	716	640		33	66	69	26,046	—
Royal National Hospital for Consumption...	325	748	663	—	—	149	17	—	—
Alexandra Hospital for Hip Disease	444	188	22	60	1	99	6	1,327	—
Banstead Surgical Home	28	36	9	10	8	17	—	—	—
Barnet Home Hospital	62	41	20	7	—	14	—	—	—
Belgrave Hospital for Children	228	597	156	247	—	34	101	35,131	787
Cheyne for Incurable ,, ...	152	74	1	18	16	50	4	—	—
East Lond. Hosp for ,, ...	986	2,040	504	951	367	114	397	91,748	4,692
Evelina Hosp. for Sick ,, ...	271	—	—	—	—	—	—	—	—
Home for Incurable ,, ...	87	55	11	—	—	43	1	—	—
Home for Sick ,, ...	152	790	—	—	141	—	5	3,861	—
Hospital for Sick ,, ...	1,083	3,175	1,206	1,088	435	199	435	110,272	804
Kensington Hosp. for ,, ...	114	167	151		—	9	10	21,593	705
North-East. Hosp. for ,, ...	964	1,482	243	925	34	123	221	69,367	5,000
Paddington Green for ,, ...	352	717	590		180	40	87	53,927	1,560
Royal Waterloo for ,, ...	195	496	113	275	13	55	46	38,072	—
St. Mary's for ,, ...	309	646	118	452	—	35	41	20,040	14,289
St. Monica's for ,, ...	89	114	88		—	20	6	—	—
Victoria Hospital for ,, ...	748	1,152	387	575	617	87	148	66,711	1,503
Victoria Home, Margate	43	150	62	24	—	48	4	—	—
Hospital for Hip Disease	49	67	—	29	—	36	—	—	—
British Lying-in	89	602	600	—	31	25	2	7,424	—
City of London Lying-in	200	676	—	672	10	24	4	27,778	—
Clapham Maternity	46	509	489		—	20	—	17,101	—
East-End Mothers' Home	87	433	431		—	18	2	12,573	—
General Lying-in	56	758	—	—	—	—	5	19,890	—
Queen Charlotte's Lying-in	556	1,701	1,692		144	—	9	19 960	65
Chelsea Hospital for Women	341	710	671		209	34	10	9,297	—
Hospital for Women	498	924	274	567	61	60	21	14,927	—
Grosvenor Hosp. for Women and Children...	195	373	130	210	—	22	6	15,876	—
New Hospital for Women	347	777	—	—	—	54	28	34,037	—
Samaritan Free	471	672	115	455	112	46	8	15,882	—
Cancer	—	804	676		55	87	113	15,809	—
Middlesex (Cancer Wing)	293	191	—	—	—	42	93	319	—
London Fever	325	852	—	790	52	50	12	—	—
Gordon for Fistula	43	311	12	298	—	20	1	5,328	—
St. Mark's ,, ...	276	563	45	446	—	39	9	5,985	—
National for Diseases of Heart, &c.	184	150	133		—	25	16	21,578	—
Female Lock	292	461	421		—	119	3	—	—
Hospital for Epilepsy, &c.	179	212	162		3	39	8	7,504	—
National for the Paralysed, &c.	1,116	867	320	200	25	153	41	44,728	—
West-End for Nervous System	325	415	279	55	22	68	13	21,659	—
Central London Ophthalmic	173	409	399		—	9	1	29,345	606
Royal Eye	303	648	628		—	18	—	84,108	2,035
Royal London Ophthalmic	1,192	2,218	2,134		12	89	5	124,404	2,063
Royal Westminster ,, ...	162	785	792		3	14	—	37,171	525
Western ,, ...	108	376	250	126	—	7	—	26,410	—
Royal National Orthopædic	119	489	379		—	87	3	9,806	—
Royal Sea Bathing Hospital	260	496	379	38	—	132	15	1,900	—
St. John's Hospital for Diseases of Skin ...	64	193	—	—	—	28	1	37,807	—
Western Skin...	—	—	—	—	—	—	—	8,884	—
St. Peter's for Stone	114	533	513		—	—	20	36,969	—
Central London Throat and Ear	47	564	42	500	3	14	5	46,859	—
Hospital for Diseases of Throat	16	723	43	660	4	13	3	46,579	6
London Throat	27	461	453	—	3	8	—	16,444	—
Royal Ear...	43	412	83	326	—	9	3	13,084	—
Royal Dental	401	—	—	—	—	—	—	53,470	—
National Dental	32	—	—	—	—	—	—	26,957	—
Estimated to supply omissions	£21,320 —	38,530 972	6,540 6,866	10,004 8,291	2,867 270	3,251 97	2,228 174	1,582,571 41,436	34,639 11,864
Total	£21,320	39,502	13,406	18,295	3,137	3,348	2,402	1,624,007	46,503

have actually seen once a little child with measles in the same bed with another with a broken leg."

We have quoted enough to illustrate our point, and we repeat that we do not suggest that horrors of the kind described existed in the hospitals of 1866, the public opinion which demands that the poor in workhouse infirmary and in hospital alike shall be treated in a manner undreamt of less than fifty years ago. We might corroborate the above account by reference to many writers of fact or of fiction, and

the names of Charles Dickens and of Charles Reade will occur readily in such a connection, but further elaboration of our point hardly seems to be needed. Times change, and those who change with them by surely we may appeal to our readers to tax themselves voluntarily upon a higher scale than once was asked of them, in order that our hospitals may ever conform to the spirit of that age. If in the humane

TABLE III.—COTTAGE HOSPITALS AND CONVALESCENT HOMES.

Name of hospital.	Hospital Sunday Fund award.	In-patients.	Relieved.	Cured.	Convalescent homes.	Remaining under treatment.	Died.	Out-patients' visits.	Accidents and emergencies
	£								
Metropolitan Convalescent (Walton)	439	2,889	1,479	1,319	—	84	7	—	—
,, ,, (Broadstairs)	287	1,869	716	1,086	—	67	—	—	—
,, ,, (Bexhill)	531	2,757	404	2,297	—	56	—	—	—
All Saints' ,, (Eastbourne)	433	3,297	1,014	2,136	—	120	3	—	—
,, ,, (St. Leonards-on-Sea)	27	229	103	126	—	—	—	—	—
Ascot Priory ,,	81	237	—	—	—	19	—	123	—
Brentwood ,,	11	140	20	120	—	—	—	—	—
Charing Cross Hospital Convalescent	70	457	—	454	—	17	—	—	—
Chelsea Hospital for Women Convalescent	49	320	318		—	—	2	—	—
Deptford Medical Mission ,,	18	147	—	—	—	—	—	—	—
Friendly Societies' Convalescent	98	1,045	—	—	—	8	—	—	—
Mrs. Gladstone's ,,	98	766	267	498	—	—	1	—	—
Hahnemann ,,	33	204	153	7	—	30	—	4,616	—
Hanwell ,,	22	220	—	—	—	—	—	—	—
Hastings Fairlight ,,	28	169	—	—	—	17	1	—	—
Hendon, Ossulston Home	62	132	—	—	—	—	—	—	—
Herbert Convalescent	33	516	253	203	—	48	—	—	—
Herne Bay (Baldwin-Brown) Convalescent	65	345	—	—	—	—	—	—	—
Homœopathic Hospital ,,	22	197	—	—	—	—	—	—	—
Hemel Hempstead ,,	35	390	74	294	—	12	—	—	—
Incorporated Morley and Bevan ,,	—	—	—	—	—	—	—	—	—
Mrs. Kitto's ,,	54	345	—	—	—	—	1	—	—
London, Hospital ,,	78	150	62	88	—	9	—	—	—
Mary Wardell ,,	65	162	—	—	—	—	—	—	—
Police Seaside Home	49	792	—	—	—	8	—	—	—
St. Andrew's (Clewer) Convalescent	108	539	119	—	—	74	8	—	—
,, (Folkestone) ,,	195	2,169	—	—	—	85	2	—	—
St. John's Home for Convalescent Children	27	346	—	—	—	72	—	—	—
St. Joseph's Convalescent	65	540	402	109	—	34	4	—	—
St. Leonards-on-Sea ,,	108	876	—	—	—	36	—	—	—
St. Mary's ,,	24	111	—	—	—	7	—	—	—
St. Michael's ,,	38	352	—	—	—	—	—	—	—
Seaside ,,	184	—	—	—	—	—	—	—	—
Acton Cottage Hospital	81	196	—	—	—	—	—	11,654	—
Beckenham Cottage Hospital	87	256	31	201	—	15	9	1,500	79
Billingsgate Medical Mission	54	72	13	53	3	—	3	13,266	—
Blackheath and Charlton Cottage Hospital	87	190	8	161	15	12	8	5,073	50
Bromley, Kent ,,	135	398	68	289	8	18	23	—	346
Bushey Heath ,,	39	138	12	98	4	15	4	740	10
Canning Town ,,	71	279	146	—	—	21	25	17,571	—
Chislehurst, Sidcup, &c., ,,	71	—	—	—	—	—	—	—	—
Coldash ,,	25	65	27	16	—	20	—	—	—
East Ham ,,	81	165	3	137	—	10	15	15,838	—
Eltham ,,	60	239	40	185	3	15	9	—	25
Enfield ,,	70	287	22	242	—	21	15	—	19
Epsom and Ewell ,,	55	132	15	106	15	7	2	—	7
Hounslow ,,	43	184	31	123	2	13	12	2,814	368
Kingston, Victoria Hospital	76	233	41	162	12	13	15	—	22
Livingstone Dartford Cottage Hospital	100	177	26	129	—	12	10	—	54
Mildmay ,,	—	230	51	120	—	28	18	—	—
Reigate and Redhill ,,	119	310	18	264	—	17	5	—	63
Sidcup ,,	43	181	34	126	1	6	10	319	41
Sutton ,,	—	155	139		—	—	7	—	—
Tilbury (Passmore Edwards) Cottage Hospital	54	—	—	—	—	—	—	—	—
Willesden ,,	119	302	289		—	20	13	—	946
Wimbledon ,,	60	208	22	163	—	10	11	107	75
Wimbledon, South, ,,	60	267	27	213	—	6	17	—	240
Wood Green ,,	57	435	—	—	—	—	26	—	—
Woolwich and Plumstead ,,	54	143	39	77	—	9	10	—	87
Hospital for Invalid Gentlewomen	108	177	9	149	—	15	2	—	—
St. Saviour's Hospital and Nursing Home	108	132	36	81	—	16	3	—	—
National Sanatorium for Consumption	108	400	401		—	83	1	—	—
Invalid Asylum	39	238	65	140	11	17	5	—	—
Fir's Home	38	57	21	—	—	20	16	—	—
St. Catherine's Home	27	46	31	—	—	12	3	—	—
Friedenheim Home for the Dying	341	136	17	3	—	32	107	—	—
Free Home for Dying	130	112	31	1	—	13	67	—	—
St. Luke's House	130	108	5	—	1	25	90	—	—
Santa Claus Home	67	42	22	1	2	20	—	—	—
Royal Mineral Water Hospital	54	1,185	1,151	18	—	123	1	—	—
Winifred House	62	46	—	—	—	18	—	—	—
Riversfield	—	429	—	—	—	47	7	2,151	—
Alexandra Home	—	23	—	—	—	—	—	—	—
	£6,350	31,079	7,128	12,000	77	1,532	598	75,772	2,432
Estimated to supply omissions	—	1,732	3,885	7,398	—	241	54	3,000	1,000
Total	£6,350	32,811	11,013	19,398	77	1,773	652	78,772	3,432

the irresistible laws of progress feel that the improved circumstances are necessary and right. If, then, poor-rates have been allowed to rise in order that workhouses may meet the claims of a newer age, treatment of the suffering poor those hospitals have set an example to the world, assuredly they have a claim upon us all for help that they may hold their own in their path of progress.

A Year for Special Effort.

If, however, we appeal for renewed and increased generosity in order that the hospitals may not fall behind in efficiency, we cannot altogether ignore those special circumstances which at this particular time may render it difficult for some donors to exercise their liberality on a scale such as they would desire. The past few years have not been marked by any such prosperity in the City of London as would enable us to expect any growth of the Metropolitan Hospital Sunday Fund traceable to it. Complaints as to the condition of "trade" are heard alike from those whose dealings of various kinds are on a large scale and from those whose business is retail, and poverty is pleaded, we are aware, in answer to many appeals, and is pleaded, moreover, by others whose incomes are not directly dependent upon commerce. It is for this reason that we insist most earnestly upon the necessity for all to give in the present year, 1903, to the fullest extent of their powers, supplementing the charity of others who may be absolutely compelled to diminish their annual contributions to charity, and exercising to the full that self-denial which renders the gift more worthy. The contribution to the Metropolitan Hospital Sunday Fund is not one which can be left to stand over until "better times." We make no comparison with the different objects upon which the money might otherwise be bestowed, but we would point to the ceaseless and pressing need of the sick and suffering.

We are all hoping for "better times," the hospitals no less than the generous persons who help them, but whereas the member of the public can curtail his expenses, the hospitals cannot do so without abandoning the very motive and aim of their existence. It is true that an individual institution may close a ward or two and reduce its expenditure upon that portion of its building to the upkeep of its fabric, but what of those who should be filling the beds in those wards? Their sickness and suffering are not postponed until a place is ready in which they may be alleviated. The operation which might save limb or life cannot stand over till trade improves and money flows more freely in its accustomed channels. The poor cannot wait to be healed, because to them sound health means the condition in which they can work to support themselves and their families, and that which incapacitates them from work means misery, loss of home, and of all that renders life tolerable to them. The life of the worker, which might be saved by prompt assistance, may be lost if he has to wait before it can be rendered. Therefore the hospitals cannot wait.

TABLE IV.—DISPENSARIES.

Name of dispensary.	Hospital Sunday Fund award.	Out-patients' visits.
Battersea Provident	£141	61,841
Blackfriars ,,	22	6,997
Bloomsbury ,,	16	5,570
Brixton, &c.	54	22,530
Brompton Provident	18	2,764
Buxton Street	22	—
Camberwell Provident	87	95,332
Camden Town ,,	16	6,943
Chelsea, Brompton, and Belgrave	49	1,793
Chelsea Provident	11	2,673
Child's Hill ,,	17	—
City	60	21,991
Clapham General and Provident	26	11,992
Deptford Medical Mission	28	10,456
Eastern	41	37,316
East Dulwich Provident	47	21,839
Farringdon General	48	7,566
Finsbury	54	30,517
Forest Hill Provident	41	5,421
Greenwich ,,	37	16,578
Hackney ,,	20	1,600
Hampstead ,,	67	41,390
Holloway and North Islington	36	1,931
Islington	65	55,909
Islington Medical Mission	43	—
Kennington and Vauxhall Provident	15	4,868
Kensal Town Provident	17	4,452
Kentish Town Medical Mission	—	4,300
Kilburn, Maida Vale, and St. John's Wood	40	3,836
Kilburn Provident Medical Institution	54	22,181
London	18	—
London Medical Mission	131	14,736
Margaret-street, for Consumption	27	6,995
Metropolitan	69	—
Mildway Medical Mission	24	5,656
Notting Hill Provident	11	6,922
Paddington ,,	33	8,200
Public	43	8,479
Queen Adelaide's	31	17,511
Royal General	29	—
Royal Pimlico Provident	52	25,186
Royal South London	50	11,296
St. George's Hanover-square	29	4,806
St. John's Wood Provident	53	18,564
St. Marylebone General	49	8,534
St. Pancras and Northern	35	—
St. Pancras Medical Mission	23	—
South Lambeth, Stockwell, & North Brixton	43	1,526
Stamford Hill, Stoke Newington	65	24,389
Tower Hamlets	51	—
Walworth Provident	18	7,540
Wandsworth Common Provident	16	6,918
Westbourne Provident	20	11,708
Western	74	24,094
Western General	120	16,621
Westminster General	48	21,572
Whitechapel Provident	38	24,946
Woolwich ,,	31	—
	£2,423	786,365
Estimated to supply omissions	—	143,572
Total	£2,423	929,937

TABLE V.—NURSING ASSOCIATIONS.

Name of association.	Hospital Sunday Fund award.	Visits.
Belvedere and Abbey Wood	£20	5,315
Brixton	31	12,699
Central St. Pancras	23	9,167
Chelsea and Pimlico	31	17,054
Hackney	30	18,742
Hammersmith and Fulham	71	28,033
Hampstead	33	8,973
Isleworth	15	9,015
Kensington	69	29,033
Kilburn	15	5,834
Kingston	48	16,274
Metropolitan (Bloomsbury)	76	32,530
St. Olave's (Bermondsey)	48	24,382
Paddington and Marylebone	54	25,192
Plaistow	122	115,043
Rotherhithe	15	6,227
Shoreditch	97	44,678
Silvertown	23	7,924
South London (Battersea)	79	45,351
Tottenham	18	—
Southwark	31	19,406
South Wimbledon	35	—
Westminster	31	16,662
Woolwich, Plumstead, and Charlton	56	18,000
East London	244	93,945
North London	84	33,918
London District	459	236,758
	£1,856	881,155
Estimated to supply omissions	—	25,000
Total	£1,856	906,155

Sick and sound alike should sympathise.

With this urgency of the sick man's need those should sympathise especially who have endured sickness, or have undergone operations at the surgeon's hands, and who are asked to realize what it means to lie idle in a humble home waiting for relief until a bed is vacant in a hospital, or to be referred from one institution to another because the wards of the first are full. These surely will not let their gifts to the hospitals wait until a year or two hence their pockets may be fuller. To the sound in health the contribution to the hospital should be a thankoffering increasing year by year in order that

others may attain that which the giver enjoys. That which many spend light-heartedly in a day or two, or, indeed, in a few hours of enjoyment, perhaps in health-giving exercise, perhaps in visiting the music-hall or theatre, perhaps in luxuries of food and drink, might, if

TABLE SHOWING THE RESULTS OF COLLECTIONS SINCE THE COMMENCEMENT OF THE FUND.

Year.	Totals.	Donations.	Year.	Totals.	Donations.
1873	£27,700	£1844	1891	£45,330	£9019
1874	29,936	1505	1892	41,512	4429
1875	26,396	1424	1893	39,290	3652
1876	27,042	1339	1894	43,679	7717
1877	26,082	947	1895	60,361	21,990
1878	24,904	1199	1896	46,035	5533
1879	26,501	1120	1897	41,003	3607
1880	30,423	1567	1898	40,397	3864
1881	31,856	1638	1899	53,504	15,310
1882	34,146	2106	1900	51,993	16,137
1883	33,935	1980	1901	54,731	18,343
1884	39,329	6410	1902	62,669	16,307
1885	34,320	2555	1903	64,975	15,766
1886	40,390	4817	1904	63,054	15,143
1887	40,607	4130	1905	78,379	29,425
1888	40,379	3080	1906	63,075	18,441
1889	41,744	3482	1907	78,651	35,865
1890	42,814	3991			

1884. Including £4500 from the International Health Exhibition.—1885, 1886, 1887. Including three donations of £1000 each from Dr. James Wakley, Editor of THE LANCET.

1891. Including £5000 from the late Duke of Cleveland, &c.

1894. Including a legacy of £5000 (less duty) from the executors of the late Mr. W. J. Whitaker.

1895. Including £10,000 from Messrs. Barnato and friends; £3400 from the Stock Exchange; £1000 from Lord Iveagh; and £1000 from Mr. J. B. Robinson.

From 1891 to 1896 Sir Saville Crossley, Bart., P.C., M.P., gave an annual donation of £1000, and since has divided his contribution between this Fund and King Edward's Fund.

1897. Jubilee year. H.R.H. the Prince of Wales started a Special Fund for Hospitals.

1899. Including £10,000 from Mr. George Herring, and £1050 from Mr. J. Lane Densham.

1900. Including a further £10,000 from Mr. George Herring, £1090 from Mr. Thos. King, and "F. H." £1000.

1901. Including a further £10,000 from Mr. George Herring, and £4000 from Sir F. Cook, Bart., M.P.

1902. Including a further £11,575 from Mr. George Herring, and £1000 from Mr. Charles Morrison.

1903. Their Majesties the King and Queen, with most of the other Members of the Royal Family, attended at St. Paul's Cathedral. Including a further £12,302 from Mr. George Herring.

1904. Including a further £11,926 from Mr. George Herring.

1905. Including a further £12,400 from Mr. George Herring, and £12,500 from the executors of Mr. F. W. Cook.

1906. Including a further £11,000 from Mr. George Herring and £3000 on account of the legacy bequeathed by Mr. Herbert Lloyd.

1907. Including £30,000 from the late Mr. George Herring's estate, and a second instalment of £3000 on account of the bequest of the late Mr. Herbert Lloyd.

saved, augment their gift to the Metropolitan Hospital Sunday Fund far beyond its usual dimensions. It would be well saved by such self-denial; it would be well spent in helping to restore to health those to whom bodily activity means the power to work; to whom rest from pressing anxiety and suffering is perhaps the highest material pleasure for which they can hope. If we suggest that for many there is no need to do more than to tax their luxuries in order to give, we do so in the consciousness that the expenditure upon luxuries and upon pleasures of all kinds is very great in modern London, and in the belief that we are asking for no overwhelming sacrifice on the part of those to whom we address ourselves. In particular we would urge generosity, even at the expense of private pleasure, upon the young; not only upon little children, but upon those who have quitted childhood, and, in the ardour of youth, pursue their own pleasures, perhaps forgetful of the pain of others. Many of these may only need to be reminded, and their hearts will prompt them to be liberal.

The Hospitals a gift from those who have to those who have not.

In conclusion, the contributions asked for by the Metropolitan Hospital Sunday Fund are charitable gifts essentially. The conditions and disabilities attaching to the receipt of poor law relief, and a certain confusion in some minds between benefits bestowed in the spirit of charity, rightly so-called, and the official doling out of funds obtained by levying a rate, have caused a certain stigma to attach to the term "charity." Those, moreover, on whom rates are levied pay a compulsory tax at the bidding of the State to be distributed by the local authority, and even the most benevolent and public-spirited among us can hardly claim that we pay our taxes with cheerful willingness, or that in doing so we are filled with kindly thoughts for those upon whom the moneys so levied will ultimately be expended. The gift of charity to the hospitals is upon a different footing; it blesses him who gives no less than it benefits its recipient, because the only compulsion upon the giver is imposed by his conscience and by his kind heart when he thinks of others in less fortunate circumstances than his own. All this might be ordered otherwise. The hospitals might be made into institutions maintained out of the rates, governed by the county or borough council, supervised by a Government department, enmeshed in red tape, and with no need to apply to the charitable for assistance. Who would be benefited by such a change? Would the sick and injured needing prompt and effective help? That is inconceivable, for now the hospitals are under the rule of those who have made them what they are, and who in their zeal on behalf of their fellows have built and organized them voluntarily for the rendering of such help and for no other object. Would the charitable gain? They would lose the object of their charity; the occasion to think of others would be gone, and the need for self-denial in order to increase their gifts would no longer be felt. On the other hand, the necessity to maintain the hospitals would still be there, imposed by statute, and enforced by the rate collector, so that the mention of the word

SUMMARY OF TABLES.

—	Hospital Sunday Fund award.	In-patients.	Relieved.	Cured.	Convalescent homes.	Remaining under treatment.	Died.	Out-patients' visits.	Accidents and emergencies
General Hospitals	£38,185	70,687	21,494	34,844	8,483	4,635	6,269	3,019,710	420,914
Special Hospitals	21,320	39,502	13,406	18,295	3,137	3,348	2,402	1,624,007	46,503
Cottage Hospitals and Convalescent Homes	6,350	32,811	11,013	19,398	77	1,773	652	78,772	3,432
Dispensaries	2,423	—	—	—	—	—	—	929,937	—
Nursing Associations	1,858	—	—	—	—	—	—	906,155	—
Total	£68,134	143,000	45,913	72,537	11,697	9,756	9,323	6,558,581	470,849

"hospital," or of the poor man's need in sickness, would but call to mind the irksome burden of a tax from which bygone generations were free. To those who now by their self-denying generosity maintain the hospitals, the law-imposed necessity to give would afford no pecuniary relief. In the first place they ask for none, and in the second the hospitals maintained out of the rates would be institutions so much more costly than those now aided by charity that the sum at present required annually can hardly guide us in estimating the amount of the rate imagined.

For we must consider to whom such hospitals would be open? The large class which now has free education provided for its children occurs to us at once in making such a calculation. To any of this class when his case is urgent such an institution now opens its doors. Would the rate-maintained civic hospital be compelled so to discriminate, or would it be likely to do so, having no question of the proper application of its limited income to consider? Would it not be open to all on demand and for all kinds of treatment, just as the public elementary day schools are open to the children of all? The rate in such circumstances would indeed be a heavy one; and would it be economically administered? Under the present system hospitals, by strict economy and by living from hand to mouth, maintain the high standard of efficiency which modern science demands, and we may here point out that the promotion and maintenance of economy and efficiency have been among the principal objects kept in view and insisted upon by those distributing the Metropolitan Hospital Sunday Fund ever since its inception. The hospitals might not fall below their present standard under the eye of a State department, but would that eye be all-seeing where the economical expenditure of easily obtained funds and the getting of "value for money" were concerned? The answer to this question may be obtained, in part, at least, by the perusal of reports recently published of official inquiries, and of legal proceedings, which have revealed reckless extravagance and in some cases alleged corruption in the administration of funds entrusted to elective local authorities. No, the generous public who maintain the hospitals of London by their free gifts, whether great or small, have nothing to gain from the municipalisation of the hospitals.

If, however, the hospitals of London are to retain their high position among the great charities of the world, the outpouring of benevolence must be liberal, and the collection of the Metropolitan Hospital Sunday Fund places before all an opportunity for the rendering of that outpouring universal. None need shrink from giving because his gift must be but small, or because he shrinks from seeing it contrasted with that of his richer neighbour. As the hospitals open their doors to all alike regardless of differences of religion or of race, provided only that poverty and suffering qualify them to receive, so the appeal is made to all whose circumstances enable them to give, however small the gift may be, and whatever may be the creed or the nationality of the giver.

The appeal is made to the vast population of London and of its neighbourhood; to the loyal subjects of His Majesty King Edward VII., who himself has not only instituted another hospital fund which bears his name, but who with his beloved Queen and with the members of his family has ever shown a deep and sympathetic interest in the financial welfare and in the working efficiency of the hospitals. It is made also to those strangers in blood who sojourn among us for longer or shorter periods and whether they may do so for business or for pleasure. It is made to the rich and to those who by comparison with the "rich" reckon themselves "poor." In responding to it, in giving and in reminding others to give, these will all be united by common goodwill, each doing his utmost in a common cause.

> "Pity and need
> Make all flesh kin. There is no caste in blood
> Which runneth of one hue, nor caste in tears
> Which trickle salt with all."

THE METROPOLITAN HOSPITAL SUNDAY FUND.

Receipts and payments for the year ending October 31st, 1907.

Dr.

1907.	£	s.	d.	£	s.	d.
To Balance at Bank of England, 1st Nov., 1906	1,100	10	3			
,, Balance, Petty Cash	24	13	8			
				1,125	3	11
,, Collections made at Sundry Places of Worship	42,786	8	11			
,, Collections at Schools	32	2	7			
,, Donations	1,060	4	1			
,, Dividend on £224 15s. 2d. Consols	5	7	0			
,, Interest on Balance of Legacy from the late Herbert Lloyd (less Tax)	136	19	7			
,, Dividend on £45,346 1s. 3d. 2½ Consols, per Executors to the Will of W. A. Gueadon, deceased	1,133	13	0			
,, George Herring's Estate— On account of Interest	30,000	0	0			
,, William Vokins' Bequest— Dividend on £22,690 16s. 3d. Consols (less Tax)	409	5	0			
,, Interest on Deposit	87	10	7			
,, Legacies— Herbert Lloyd, second instalment of legacy of £10,000	3,000	0	0			
				78,651	10	9
				£79,776	14	8

Cr.

1907.	£	s.	d.	£	s.	d.
By Awards to 147 Hospitals	62,501	13	8			
,, Awards to 12 Institutions	1,213	6	8			
,, Awards to 57 Dispensaries	2,420	13	8			
,, Awards to 27 Nursing Associations	1,856	5	0			
,, Surgical Appliances	4,077	11	5			
				72,069	10	5
,, Rent	251	5	0			
,, Insurance	0	7	6			
,, Furniture and Repairs	16	0	1			
,, Fuel, Lighting, and Office Cleaning	37	0	5			
,, Printing and Stationery	258	16	8			
,, Postages	144	10	8			
,, Telephone	11	5	10			
,, Advertisements	152	14	0			
,, Salaries and Gratuities	1,393	19	2			
,, Pension to late Secretary	250	0	0			
,, Special Appeal	1,014	2	4			
,, Sundries	7	16	10			
,, Law Charges	81	1	4			
				3,618	19	10
,, Balance at Bank of England, 31st Oct., 1907	4,079	5	3			
,, Petty Cash	8	19	2			
				4,088	4	5
				£79,776	14	8

Audited and found correct, this 21st day of November, 1907.

(Signed) W. H. PANNELL & Co., *Chartered Accountants*, 13, Basinghall-street, E.C.

*** *In the preparation of the voluminous statistics of hospital work which have been here digested and exhibited in collected form (and which have been specially supplied to us in response to our applications, and are quite independent of any returns made to the Metropolitan Hospital Sunday Fund Committee), we have been greatly indebted to a large number of secretaries and other officers of the various medical charities of the metropolis. To them we desire, as on many previous occasions, to tender our sincere thanks.*—ED. L.

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